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WINTER 2004 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 6 NO. 1

MHNews Honors

American Association

of Suicidology

See Page 11

Understanding and Coping With Suicide

National Institute of Mental Health Washington, DC

uicide is a tragic and potentially preventable public health problem. In 2000, suicide was the 11th leading cause of death in the United States. Specifically, 10.6 out of every 100,000 persons died by suicide. The total number of suicides was 29,350, or 1.2 percent of all deaths. Suicide deaths outnumber homicide deaths

by five to three. It has been estimated that there may be from eight to 25 attempted suicides per every one suicide death. The alarming numbers of suicide deaths and attempts emphasize the need for carefully designed prevention efforts.

Suicidal behavior is complex. Some risk factors vary with age, gender and ethnic group and may even change over time. The risk factors for suicide frequently occur in combination. Research has shown that more than 90 percent of

people who kill themselves have depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorders. Also, research indicates that alterations in neurotransmitters such as serotonin are associated with the risk for suicide. Diminished levels of this brain chemical have been found in patients with depression, impulsive disorders, a history of violent suicide attempts, and also in postmortem brains of suicide victims.

Adverse life events in combination with other risk factors such as depression may lead to suicide. However, suicide and suicidal behavior are not normal responses to stress. Many people have one or more risk factors and are not suicidal. Other risk factors include: prior suicide attempt; family history of mental disorder or substance abuse; family history of suicide; family violence, including physical

see NIMH on page 26

Providing Hope on the Subject of Depression and Suicide: A Documentary Filmmaker's Personal Journey

By Liisa K. Hyvarinen Freelance Journalist

et me begin my story with an excerpt from an interview I did in May of 2000 with CBS News 60 Minutes correspondent Mike Wallace, for my documentary, "Silent Screams."

Wallace: Depression...there was a stigma attached to depression. You're a little mentally crazy or something like that sort and you don't want to acknowledge that and so I didn't want to acknowledge it and nobody in the office knew. (Laughing) They knew I was strange but I've always been strange so they figured what the dickens Mike is just a little more difficult than usual.

Hyvarinen: Some people say that you can just snap out of it?

Wallace: You cannot snap out of it. You cannot. I mean pull yourself up come on I used to think come on, Mike, don't pamper yourself, you've got the blues, you've had the blues before, get out of it. It isn't the blues. It's something much deeper than that.

Hyvarinen: In the beginning you chose not to tell people.

Wallace: That's right. I was not going to tell anybody.

Hyvarinen: Why?

Wallace: Because you feel as though this man turned into a nut case. There's this stigma. It shouldn't be anymore.



CBS News 60 Minutes correspondent Mike Wallace discusses the stigma of mental illness during his interview for the documentary *Silent Screams*

And lots of people have come out of the closet (laughs) out of the closet about it (depression). People of some accomplishment. And they say the worst thing you can do is to feel ashamed of it. You wouldn't be ashamed if you had Scarlet Fever or if you had a cold or if your appendix burst. Truly this is simply an illness. And you get over it.

Mike Wallace sat down with me for an interview about his depression and his personal battles with suicidal thoughts when I was preparing a five-part TV news series and documentary titled "Silent Screams" about that subject matter. Wallace had first been diagnosed with depression in the early 1980s and hearing his candid remarks resonated with me. I could understand why he had tried to conceal his condition because of the stigma associated with mental illness. For a successful and respected newsman whose entire career was based on his quick brain and ability to investi-

gate complex news stories, exposing his own illness could have been career suicide. But "coming out of the closet" about his depression — as Wallace jokingly called it — had not been a devastating experience for him. Quite the contrary.

As we wrapped up the interview and Wallace stood up to leave I wished my own father could have heard this news legend's encouraging words.

"Wake up, sweetie," I could hear my mother saying very softly. "I need you to get up. I need to tell you something," she added quietly but even through my sleep I could tell from her tone of voice something was wrong. Rubbing my eyes like any other 14-year-old at six o'clock in the morning I looked up and saw my mother sitting on the edge of my bed. She looked tired but as she reached out to run her fingers through my hair and pat me on the cheek her motions seemed frozen almost robot like. I looked up and asked: "What's wrong, Mom?" And my mother uttered what she has told me later on were the hardest words she ever had to tell me. "Your father is no longer here. He died last night while you were

It was February 1983. My father, who had battled clinical depression for years, had taken his own life. A son, a husband and a father of three, my father was also an accomplished scientist and a man who loved to entertain and tell jokes.

see Journey on page 16

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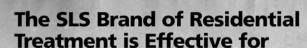


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The Publisher's Desk

Suicide "Sucker-Punch"

By Ira H. Minot, Publisher and Founder, Mental Health News



Ira H. Minot, CSW

epressing circumstances certainly come in all shapes and sizes. Difficulties in the arena of love and relationships, careers, financial situations and all of the different ways people measurer their self worth can't help but leave us feeling vulnerable at some time in our lives.

For some, life's disappointments inflict deeper psychic wounds then in others. Since September 11th we have become more open to and aware of the fact that emotional disturbances can lead to more serious outcomes and that none of us are immune.

When it comes to our physical health, situations are more openly discussed, less stigma exists, and ample supports are provided when a problem arises.

In some dark and protected place within us all is the dread that our next annual physical will disclose a lump that needs further examination, or an unusual finding in our routine blood test. With luck and good medicine, our prognosis is hopefully better than we probably imagine. That is due in part to a billion dollar medical industry that continues to make groundbreaking discoveries in diagnostic equipment and treatment procedures that have turned the corner on many previously deadly diseases.

Unfortunately when it comes to grappling with a disorder of the mind, the playing field is not quite as level. Since maladies such as schizophrenia, anxiety disorders and depression do not show up in a simple blood test, seen on a common x-ray, or further investigated with an MRI, their cause, degree, and future course present a mystery and relative puzzle waiting to be solved.

But the fact is, that mental illness will

strike 20% of the population—that is one in five persons will at some time in their life, experience some form of mental illness.

Mental illness, by its very nature, poses a nasty conundrum for everyone involved. The players include the patient (consumer) presenting symptoms, his or her loved ones (and employer perhaps), and the treatment professional who will be seen to treat the case. Lets look at them in reverse order.

The treatment professional be they a Psychiatrist, Psychologist, or Psychiatric Social Worker, should have the necessary skill and experience to diagnose the problem. However, the diagnosis and treatment of mental illnesses is fraught with challenges and very often takes months or perhaps years to correct. The presenting symptoms may be at their earliest stages of the patient's problem or may be presented as a sudden or recurring full blown episode. In addition, the patient's age, education, financial resources (including health insurance) and support network may detract from or improve the eventual outcome. Finally, the type of presenting symptoms may heighten the fear and confusion within the world surrounding the patient, which increases the difficulty they have in coping with day to day existence.

Suicide, a thought that may have never before entered a person's vocabulary, may suddenly appear as a result of the sudden confusion and pain inflicted by their psychic difficulties.

Loved ones, friends and employers play an important role in the typical scenario of mental illness. They may help the situation by providing unconditional emotional support, concrete direction towards help, and convalescent care. However this typically is the exception rather than the norm. In many cases well intentioned friends and family may actually make the situation worse. In some instances their inability to understand that the patient may be in harms way quickly becomes a critical factor. Since employers may be the sole source of financial resources for the patient, they pose an enormous threat to a positive prognosis and final outcome. More often than we would hope, many employers are quick to terminate people suffering with a mental illness.

The positive side to this investigation, which I will address in a moment, are the many programs and services available within the mental health community surrounding the patient. Unfortunately this world may not be known to the patient, or be promoted by the professionals treating the individual.

First and foremost, the patient is a person, not a case history or a medical reimbursement category. They have a life, they have feelings, and most certainly they have hopes and dreams. They may be a child or an adolescent at the doorstep to a future filled with gleeful anticipation. They may be a young adult building an education for their role as a productive adult. They may be a

parent, a teacher, a husband or wife, a son or daughter, a doctor, a lawyer or a candlestick maker.

Nobody can say exactly, when and why a psychic disturbance takes hold of a person. All we know is that it does. We notice something is not right or they tell us that they are not feeling right.

Imagine for a moment, that you are going through your normal daily routine at home, work or school and suddenly a strange and totally foreign feeling comes over you. It may perhaps be isolated to a part of your body such as your abdomen, limbs, chest or head or a full body feeling. You may not even know how to describe what it is exactly you are feeling, but it doesn't feel normal. You may feel tired or too energetic, too slow in thinking or have thoughts racing into your head at an abnormally high rate of speed. You may feel like you're having a heart attack because there is a pounding in your chest, or you are hearing or seeing things that you have never encountered. You hope that it's just a passing fever, but when it happens again tomorrow, you get scared and a sense of gloom or panic may begin to invade your usual demeanor and sense of self.

You may have tried to hide the fact that you're not yourself, but people around you start to notice and question your condition. It's a hard thing to explain to people, and you may not even have anyone that you can turn to. What do you do?

Many people go alone or are brought to the doctor or an emergency room by a friend or family member. In most cases, a heart attack is quickly ruled out, and you are told you are depressed or are having an anxiety attack. In many cases you are given time off for a few days of rest, perhaps given a mild tranquilizer or anti-anxiety medication and the storm passes. Perhaps it passes for a period only to reappear with more intensity. You may not have taken this occurrence seriously. You throw the medications away due to their side-effects and implication that you are a crazy person. In many cases the stigma of having a mental problem caused you to deny its existence—hoping that it was just a fluke.

Mood disturbances, be they elevated or depressed cause many people to withdraw from their normal activities of life. Many try to self medicate with drugs or alcohol. Staying in bed for longer periods of the day and avoiding contact with people may provide transient relief but quickly add to the downward spiral of a mental illness if continued for a long period of time. Since mental illnesses are so varied, the treatments given may not immediately solve the problem. Typically, a combination of medication and talk therapy are applied to arrest the problem. Unfortunately, this is not an exact and problem-free science. Weeks may pass while various medications are tried. Unless the patient is vigorously monitored, serious downward spirals in the form of hopelessness and pain lead many to thoughts of suicide.

Isn't suffering from a psychic disorder such as depression quite enough to deal with? Thoughts and acts of suicide serve as a "low blow" for victims to have an even chance at weathering the storm. That's the unexpected suicide sucker-punch.

The statistics as reported by the American Foundation for Suicide Prevention at www.afsp.org make this fact perfectly clear.

- More than 29,000 people in the United States kill themselves every year.
- Suicide is the 11th leading cause of death in the U.S., accounting for 1.3% of all deaths.
- A person dies by suicide about every eighteen minutes in the U.S.
 An attempt is made an estimated once a minute.
- There are more than four male suicides for every female suicide. However, at least twice as many females as males attempt suicide.
- Every day, approximately eighty-six Americans take their own life, and 1500 attempt. There are an estimated eight to twenty-five attempted suicides to one completion.

What more can be said? I myself have been down this dark and dangerous road—so I know it happens and it defies comprehension or description.

What I will say and plead to anyone who finds themselves in such a dark and dangerous place is this: whatever you are feeling right now is not your fault but rather an illness that is treatable. Please understand that this storm will eventually pass, and that you must continue to try to find the help that you need.

What you may not realize is that there are programs and services within the mental health community near you. Here at *Mental Health News*, our mission is to provide you with a source of information, education, advocacy and recourses. Our worst enemy is fear, which stems from a lack of education and understanding of mental illness.

Suicide rates have declined in some areas within the last 5 years—suggesting that aggressive educational campaigns and the kinds of programs and services that are featured in this issue of Mental Health News are making a difference.

We are in the midst of the holiday season, which can be a most difficult time for many who battle mental illnesses. I urge you to reach out to those around you in need. Become a volunteer and get involved in supporting organizations in your community such as the Mental Health Association (MHA) and the National Alliance for the Mentally Ill (NAMI). Remember, mental health is about us all, and *you* can make a difference in someone's life.

Have A Great Winter! Ira H. Minot, CSW

Editorial to The Publisher

Suicide By "Cop" And Related Sociocultural Phenomena

An Editorial By Joseph A Deltito M.D.



Joseph A. Deltito, M.D.

n December 26, 2000 in the usually quiet Boston Suburb of Wakefield, Massachusetts Michael McDermott an employee at an Internet consulting firm proceeded down a hallway with a rifle, shotgun and a pistol in his hands. After the next 7 minutes passed 7 of his coworkers and bosses were shot dead. He then sat among the bloody bodies and awaited the SWAT team dispatched to the scene. In this case they did not kill. His words to the police, "I don't speak German." He is later convicted of these crimes despite a vigorous defense which included several Psychiatrists who offer testimony that he is Schizophrenic and depressed. It is on record that he has made at least one suicide attempt in the

On the 110th anniversary of the birth of Adolph Hitler, April 20 1999, two teen age boys, Eric Harris and Dylan Klebold leave 13 dead in a Littleton, Colorado high school. The name Columbine High School will live on in His-

tory as the "signature" event of it's type. Both boys were members of a group who wore long black trench coats to school and appeared to be known by many as angry and troubled.

I could list many more similar incidents which unfortunately are too familiar to you now reading this article. When watching TV and there is an urgent news override of the ongoing programming, if the initial scene is a school or post office, do not most of us think: "It has happened again." In fact the term, "Going Postal" has now entered the everyday vernacular to describe someone who seems to wantonly shoot up his place of employment or school. These are generally portrayed by the media and spoken of as homicides, surely there is justification for doing so. What I submit is that similar incidents are better understood, and more properly referred to as elaborate Suicides as the perpetrators rarely expect to live through the day. They are often "neutralized" by policemen at the scene: Suicide by Cop.

It is an important distinction to make between suicide and homicide as each has its own epidemiology and treatments (Interventions). It is of the utmost importance for we as a society to understand these situations so they can be aborted and avoided. In general the elements are these. The perpetrator or perpetrators are usually marginalized from the mainstream culture or subculture, they suffer from some formal psychiatric illness, they feel bullied or unfairly picked upon and they do not receive adequate psychiatric treatment. They may suffer from the types of personalities which leave them feeling a shallow sense of their own self-importance.

In the Canterbury Suicide Project, conducted by Professor Annette Beautrais and colleagues at the Christ-Church School of Medicine in New Zealand, extensive analyses was performed on all serious suicide attempts in youths on the South Island of New Zealand. Many important findings have emerged from the psychological autopsies they performed in this study. Clearly in the case of those who attempt (many of whom completed) suicide most were known to the system as troubled individuals, most with apparent psychiatric illness, particularly Depression. Their schools, families and doctors clearly saw them at risk. Youth suicide has been on the increase in New Zealand, Australia. the United States and around the world where it has been adequately studied. An ever increasing trend seems to be that a subgroup of suiciders decide to take a bunch of others with them. The victims are most often the very people who teased and bullied them in school or belittled them in places of employment. The "Post Office" remains an interesting microcosm as many individuals are employed there in relative isolation with a very direct and at times severe chain of command over them. The work frequently attracts those who are otherwise loners and may become over invested in their jobs. A uniform can sometimes reinforce the sadistic pettiness of bosses and a recipe for disaster can be placed on a slow boil. All it takes is being passed over for promotion, not allowed a holiday off, a reprimand for an unclean uniform and a person, if also suffering from depression or psychosis, may go boiling over into mayhem.

Clearly, most individuals with even the most severe and persistent forms of psychiatric illness are of no danger to the general public. Yet it would be untrue to say that of those who commit such violent crimes do not suffer in most cases from legitimate illnesses. In this country there appears to be a growing mentality, especially in our public schools, for teachers, counselors and administrators not to "confront" obviously troubled kids who may be telegraphing their distress through the clothing and grooming they choose and the "bad" behaviors that may demonstrate. From a public health point of view what is necessary is to identify and treat the subset at risk. Fears still persist in schools and other settings to not "label" children with Psychiatric diagnoses, yet to not do so in the face of bonefide signs and symptoms of distress is criminal to the child and our culture. The Michael McDermotts of the world are generally known to those around them as disturbed well before their crimes are committed. Increasingly in the age of Managed Care and HMO's less and less experienced practitioners are used for evaluating our children in need; general practitioners and social workers are used as psychiatric screeners instead of seasoned well trained Child and Adolescent Psychiatrists. when the potentially "Postal" individuals are identified, more often than not they

do not receive adequate care as it might adversely effect the bottom line of an insurance company or state mental health facility. So the first prong of dealing with these situations is to identify those at risk and treat any formal psychiatric illness vigorously. The next prong might be more difficult.

Many would say our society is in decline, I certainly would be among them. There are many things I as a psychiatrist can learn through an understanding of the "POP" culture as it both reflects and effects the general population. I think there is an important lesson that can be learned through the recent popularity of so-called "Reality" TV shows. Personality traits and questionable behavior that previously might have been seen to exist only in a small percentage of the population is now exalted as normative behavior: that is in "delighting" in the misfortunes and ridicule of others. Whom gets voted off the island to the survivors delight is unfortunately being played out in almost every high school in America. A group gets defined who sets the standards for who belongs and who can be jettisoned from their small clique or society: too fat, you're out...parents not rich, you're out... talk with an accent, you're out...etc., etc., etc. We are becoming a less inclusive society and delighting in our Survivorhood, until of course it is us that is excluded, marginalized or just plain "kicked-out." I think we need to set a better standard for our children to be kinder to other children. At a recent conference at my daughter's school I heard the discussant say: "You can't legislate kindness," when asked about how parents should handle their children excluding others (non-desirables) from play, parties, cafeteria tables, etc. Yet if we can not legislate kindness what can we do as parents to ease the suffering of those who one day may feel "my life is no longer worth living, and by the way I will take a few of you with me.'

Joseph A. Deltito, M.D. is a Clinical Professor of Psychiatry at New York Medical College and has an office practice for psychopharmacological consultations and forensic psychiatry in Greenwich, Connecticut. He is a frequent contributor to Court TV. Dr. Deltito serves on the Clinical Advisory Board of Mental Health News.

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Ira H. Minot, C.S.W., Founder & Publisher

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Mental Health



NewsDesk

Department of Health and Human Services Announces Medicare Premium and Deductible Rates

Dept. of Health and Human Services Washington, DC

he Department of Health and Human Services (HHS) just announced the Medicare premium, deductible and coinsurance amounts to be paid by Medicare beneficiaries in 2004.

For Medicare Part A, which pays for inpatient hospital, skilled nursing facility, and some home health care, the deductible paid by the beneficiary will be \$876 in 2004, an increase of \$36 from this year's \$840 deductible. The monthly premium paid by beneficiaries enrolled in Medicare Part B, which covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items, will be \$66.60, an increase of 13.5 percent or \$7.90 over the \$58.70 premium for 2003.

Medicare deductibles and premiums are updated annually in accordance with formulas set by law. The Part B premium is required to be the amount needed to cover 25 percent of estimated program costs for enrollees aged 65 and older. General revenue tax dollars cover the other 75 percent of the costs. The same statute prescribes the method for



Tommy G. Thompson

computing the Part A inpatient hospital deductible.

"These premium changes underscore the need to improve and modernize the Medicare program," HHS Secretary Tommy G. Thompson said. "We need a Medicare system that provides more choices for beneficiaries and more incentives for efficient, high-quality care. Choice and efficient care can help keep Medicare spending and Medicare premiums affordable as well as help us down the road to preserving Medicare for future generations."

Most Medicare beneficiaries enrolled in Part B pay the monthly premium. The Part A deductible applies only to those enrolled in the original fee-for-service Medicare program. Those who enroll in private Medicare+Choice plans may not be affected by the Part A increase, and may receive additional benefits with different cost-sharing arrangements.

About 95 percent of Medicare's 41.7 million beneficiaries are enrolled in the optional Part B, which helps pay for physician services, hospital outpatient care, durable medical equipment and other services, including some home health care. Nearly 90 percent also have some form of supplemental coverage (such as Medigap, Medicaid, or Medicare+Choice) to help reduce out-of-pocket medical costs.

The Part A deductible is the beneficiary's only cost for up to 60 days of Medicare-covered inpatient hospital care. However, for extended Medicare-covered hospital stays, beneficiaries must pay an additional \$219 per day for days 61 through 90 in 2004, and \$438 per day for hospital stays beyond the 90th day in a benefit period. For 2003,

per day payment for days 61 through 90 was \$210, and \$420 for beyond 90 days. For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 will be \$109.50 in 2004, compared to \$105 in 2003.

Most Medicare beneficiaries do not pay a premium for Part A services since they have 40 quarters of Medicare-covered employment. However, seniors and certain persons under age 65 with disabilities who have fewer than 30 quarters of coverage may obtain Part A coverage by paying a monthly premium set according to a formula in the Medicare statute at \$343 for 2004, an increase of \$27 from 2003. In addition, seniors with 30 to 39 quarters of coverage, and certain disabled persons with 30 or more quarters of coverage, are entitled to pay a reduced premium of \$189.

States have programs that pay some or all of beneficiaries' premiums and coinsurance for certain people who have Medicare and a low income. Information is available at 1-800-MEDICARE (800-633-4227) and, for hearing and speech impaired, at TTY/TDD: 877-486-2048.

Information concerning the Social Security Cost of Living increase for 2004 was also released today and can be found at www.ssa.gov.

Parity Legislation Still Awaits As We Remember Senator Paul Wellstone

NAMI Washington, DC

ctober 25 marked the 1st anniversary of the passing of an unrivaled champion for people living with severe mental illness and their families – Senator Paul Wellstone. In memory of his legacy and in celebration of his life, NAMI advocates are urged to call their members of Congress this week and urge immediate action on mental illness insurance parity legislation (S 486/HR 953 – the Paul Wellstone Mental Health Equitable Treatment Act of 2003).

Paul Wellstone's life and service in the United States Senate was grounded in his personal experience as a family member of a brother living with schizophrenia and his unending quest to end discrimination against children and adults living with mental illness. While his work was not finished before his death, his legacy of activism lives on. In the year since his passing, a bipartisan coalition of Senators and House members has continued the cause for which he worked for passionately – legislation to require health plans to cover treatment for mental illness on the same terms and conditions as all other illnesses – insurance parity. This legislation remains stalled in Congress, despite support from 66 Senators, 243 House members and President Bush.

Advocates are urged to call their members of Congress and urge them to move the Paul Wellstone Mental Health Equitable Treatment Act of 2003 forward immediately and pass it before Congress adjourns for the year. Senators should especially be urged to contact Majority Leader Bill Frist (R-TN) and Senate HELP Committee Chairman Judd Gregg (R-NH). Likewise, House members should be urged to contact Speaker Dennis Hastert (R-IL) and the Chairmen of the three House Committees that continue to delay action on parity legisla-

tion: Chairman John Boehner (R-OH) of Education and the Workforce, W.J. (Billy) Tauzin (R-LA) of Energy and Commerce and Bill Thomas (R-CA) of Ways and Means.

All Senators and House members can be reached through the toll-free Parity Hotline, 1-866-PARITY4 (1-866-727-4894). The Parity Hotline reaches the Capitol Switchboard, which can connect callers to their members of Congress.

When calling members of Congress, remind them that:

• President Bush supports efforts in Congress to pass a federal parity bill and on April 29, 2002 declared "Senator Domenici and I share this commitment: health plans should not be allowed to apply unfair treatment limitations or financial requirements on mental health benefits. It is critical that we provide full mental health parity and that we do not significantly run up the cost of health care,"

- untreated mental illness costs American businesses, government and families at least \$79 billion annually in lost productivity and unemployment, broken lives and broken families, emergency room visits, homelessness and unnecessary use of jails and prisons,
- mental illnesses such as schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder and severe anxiety disorders are real illnesses,
- treatment for mental illness works, if you can get it – treatment efficacy rates for most severe mental illnesses exceed those for heart disease and diabetes,
- there is simply no scientific or medical justification for insurance coverage of mental illness treatment to be on different terms and conditions than other diseases,

see Parity on page 55

Mental Health



NewsDesk

Mutant Serotonin Transporter Gene Is Linked To Obsessive Compulsive Disorder

National Institute of Mental Health Washington, DC

nalysis of DNA samples from patients with obsessive compulsive disorder (OCD) and related illnesses suggests that these neuropsychiatric disorders affecting mood and behavior are associated with an uncommon mutant, malfunctioning gene that leads to faulty transporter function and regulation. Norio Ozaki, M.D., Ph.D., and colleagues in the collaborative study explain their findings in the October 23 Molecular Psychiatry.

Researchers funded by the National Institutes of Health have found a mutation in the human serotonin transporter gene, hSERT, in unrelated families with OCD. A second variant in the same gene of some patients with this mutation suggests a genetic "double hit," resulting in greater biochemical effects and more severe symptoms. Among the 10 leading causes of disability worldwide, OCD is a mental illness characterized by repetitive unwanted thoughts and behaviors that impair daily life.

"In all of molecular medicine, there are few known instances where two variants within one gene have been found to alter the expression and regulation of the



gene in a way that appears associated with symptoms of a disorder," said coauthor Dennis Murphy, M.D., National Institute of Mental Health Laboratory of Clinical Science. "This step forward gives us a glimpse of the complications ahead in studying the genetic complexity of neuropsychiatric disorders."

Psychiatric interviews of the patients' families revealed that 6 of the 7 individuals with the mutation had OCD or OC personality disorder and some also had anorexia nervosa (AN), Asperger's syndrome (AS), social phobia, tic disorder, and alcohol or other substance abuse/dependence. Researchers found an unusual cluster of OCD, AN, and AS/autism, disorders together with the mutation in approximately one percent of individuals with OCD.

The scientists analyzed DNA from 170 unrelated individuals, including 30 patients each with OCD, eating disorders, and seasonal affective disorder, plus 80 healthy control subjects. They detected gene variants by scanning the hSERT gene's coding sequence. A substitution of Val425 for Ile425 in the sequence occurred in two patients with OCD and their families, but not in additional patients or controls. Although rare, with the I425V mutation found in two unrelated families, the researchers propose it is likely to exist in other families with OCD and related disorders.

In addition to the I425V mutation, the two original subjects and their two siblings had a particular form of another hSERT variant, two long alleles of the 5-HTTLPR polymorphism. This variant, associated with increased expression and function of the serotonin transporter, suggests a "double hit," or two changes within the same gene. The combination of these changes, both of which increase serotonin transport by themselves, may explain the unusual severity and treatment resistance of the illnesses in the subjects and their siblings.

"This is a new model for neuropsychiatric genetics, the concept of two or maybe more

see Gene on page 55

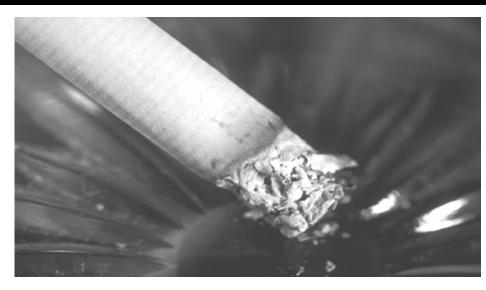
Research Shows Cigarette Smoking Reduces Levels of MAO in Organs Outside of Lungs

Dept. of Health and Human Services Washington, DC

t is well known that smoking cigarettes can directly and often fatally damage the lungs. But new research, with support from the National Institute for Biomedical Imaging and Bioengineering and the National Institute on Drug Abuse, National Institutes of Health, and the Department of Energy, shows that cigarette smoke also decreases levels of a critical enzyme called monoamine oxidase B (MAO B) in the kidneys, heart, lungs, and spleen. Too much or too little of this crucial enzyme can have an effect on a person's mental or physical health.

nerve cells to communicate and regulate blood pressure.

PET, or positron emission tomography, employs computer technology and



MAO B is important because it radioactive compounds to produce im- States alone," says NIH Director Dr. reaks down the chemicals that allow ages of biochemical processes within Elias Zerhouni. "This new finding highliving systems.

"Smoking is a major public health problem that results in approximately 440,000 deaths per year in the United lights the fact that the act of smoking cigarettes can affect biochemical systems within multiple organs other than the lungs and upper airways."

"When we think about smoking and the harmful effects of smoke, we usually think of the lungs and of nicotine," says NIDA Director Dr. Nora D. Volkow, one of the authors of the study. "But here we see a marked effect on a major body enzyme in sites far removed from the lungs that we know is due to a substance other than nicotine. This alerts us to the fact that smoking, which is highly addictive, exposes the whole body to the thousands of compounds in tobacco smoke."

Dr. Joanna Fowler, together with Dr. Volkow and others at Brookhaven National Laboratory and the State University of New York at Stony Brook, conducted the study, which will be published online during the week of September 8 on the Proceedings of the National Academy of Sciences Web site.

Dr. Fowler and the research team compared PET scans showing MAO B activity in 12 smokers with scans from 8 nonsmokers.

see Smoking on page 55

Mental Health



NewsDesk

Supported Employment in the Hudson River Region

By Jack Smitka, Vocational Liaison NYS-OMH Hudson River Field

t was difficult for Mary to even imagine a functional life outside of her world of anxiety and clinical depression. Her struggle with mental illness has led her to access an array of inpatient and outpatient mental health services. Years of physical and mental abuse had her convinced that, at middle age, she was virtually worthless. It is a story that may be familiar to you. Mary was living day to day with her perception of reality until she met a representative of PEOPLe, Inc. PEOPLe is a peer support and advocacy program in Poughkeepsie, NY. PEOPLe, in a cooperative relationship with the Dutchess County Continuing Day Treatment Center, reaches out to individuals, like Mary, to promote the value of work. Fear and self-doubt are their opponents, but an "if I can do it, you can do it too" attitude is the strength of their game.



The peers at PEOPLe work individually and in group sessions to explore an individual's vocational needs and desire to work. They identify personal values and potential barriers to employment. Life skills assessments, which include an inventory of work interests, experiences and skills, are completed in coordination with Gateway Community Services. Gateway is based in Kingston, NY and was selected as one of seven original mental health providers in New York

State to participate in a NYS Office of Mental Health (OMH) funded demonstration project called Performance Based Contracting (PBC). PBC, also know as the milestone project, is a funding initiative designed to stimulate focused supported employment (SE) implementation. Demonstration project contractors are provided financial incentives for successfully completing performance outcomes or milestones. The Dutchess County/Gateway initiative is

the only PBC project in NYS with this unique collaborative peer support relationship.

Gateway's PBC project, with the support of PEOPLe, worked with Mary to establish her in a Section 8 apartment. Mary calls it taking little steps, but with her housing situation stabilized she felt that she was ready to move on with her life. With the strong support of the milestone manager, Sandy, Mary has been employed, as a hostess at a local Pizza Hut, for 16 months now. She receives follow along services, such as benefits counseling, on two occasions every month. Her intellect and personality are starting to reemerge. She is now interested in continuing her education to expand her employment options. She even saved up enough money to take a cruise recently.

Mary's life has changed dramatically because of this effective collaborative effort of mental health services. The Office of Mental Health

see Hudson on page 50

Columbia University Researchers Present At Hudson Valley MHA Suicide Symposium

By Ann Marie Maglione Director for Community Relations MHA in Orange County

ental Health Association in Orange County, Inc. (MHA) is on the cutting edge in providing accessible mental health services as well as educating the public regarding mental health issues. The foundation for our services is an evidence-based approach to recognizable problems.

Throughout the year, MHA in Orange County offers a variety of educational programs and support groups on mental health issues for professionals and the public including conferences, seminars, training for family members and mental health screening programs.

A major focus of MHA is to link individuals at-risk to the appropriate services to prevent adverse outcomes such as family disruption, job loss and suicide. On line depression screening is available on the MHA in Orange County's website www.mhaorangeny.com throughout the year. This confidential screening is available to all and is the first step in receiving treatment and in many cases, preventing suicide. In addition, a 24-hour information and referral HELPLINE 800.832.1200 is available.



Community education is MHA's forte. We continue to strive in order to make mental health issues a priority in schools. We integrate the schools with MHA by offering a variety of conferences, seminars and outreaches. Some of the topics discussed are, sexual assault, date rape, eating disorders and peer pressure. Each of these separately, if allowed to fester without intervention could potentially lead to suicidal thoughts.

On November 18, MHA in Orange County co-sponsored a presentation on suicide prevention by researchers from the Department of Psychiatry at Columbia University. Among the finding of researchers at Columbia are: "Treatment of psychiatric illnesses will reduce suicide rates. Psychological observations in completed suicides confirm that over 90% have a diagnosable psychiatric illness and only 12% of suicides during an

episode of major depression were receiving at least a minimal therapeutic dose of medication". These studies will be discussed in further detail when MHA, in collaboration with the Orange County Department of Mental Health and Orange Regional Medical Center, Arden Hill campus will host the Annual Jeanne Jonas Professional Development Symposium. The topic will be titled "Suicide Prevention, working with recipients who have a history of suicide attempts and persons at risk for suicide ".

Please visit our website for more information regarding the Jeanne Jonas Symposium and a variety of other events.

MHA seeks to promote the mental health and emotional well being of Orange County residents, working toward reducing the stigma of mental illness, developmental disabilities, and providing support to victims of sexual assault and other crimes through 23 programs and several support groups.

MHA shares the belief that every person has dignity and is to be treated with respect, compassion and acceptance.

The MHA in Orange County is located at 20 Walker Street, in Goshen, New York. You may contact their office at (845) 294-7411.

FOR THIS SPECIAL SUICIDE ISSUE MENTAL HEALTH NEWS TAKES PRIDE IN HONORING THE

AMERICAN ASSOCIATION OF SUICIDOLOGY

FOR ITS DEDICATION TO THE UNDERSTANDING AND PREVENTION OF SUICIDE

Suicide in America: What We Know, and the Challenges that Lie Ahead

By Alan L. Berman, Ph.D. Executive Director, American Association of Suicidology

uicide happens! In 2001 (the latest year for which we have national statistics), 30,622 Americans completed suicideone every seventeen minutes; eighty per day. What surprises most people to learn is that 75% more Americans die by suicide each year than die by homicide. What may surprise most people to know is that the great majority of these tragic and premature deaths are preventable.

Suicide is our 11th leading cause of death. Among the young, however, it ranks third. It is four times more frequent among men than women; twice as frequent among whites than blacks; and particularly more common among the elderly. But there is no category of people that is immune to the possibility that loved ones will carry a lifetime label of suicide survivor.

Moreover, for every completed suicide in the U. S. there are 5 people hospitalized each year for a nonfatal attempt and an estimated 22 emergency department visits for less lethal self-harm behaviors – totaling almost 700,000 hospital admissions annually for nonfatal suicidal behaviors. Whereas completed suicides are much more frequent among males, nonfatal attempts are made by females three times as often as by males, and the great majority of these are among our young.

Since 1991, the Centers for Disease Control and Prevention (CDC) biannually has surveyed an average of about 15,000 high school students regarding their self-reported risk behaviors. Their findings are disquieting. In their 2001 survey, almost one in 5 students reported seriously considering suicide in the past 12 months, one in seven said they had made a plan, and one in 12 reported having made a nonfatal attempt, for which one third of these youth had to seek medical attention. In a typical American high school classroom, two females and one male will make a suicide attempt this year.

Before age 65, a total of more than 500,000 years of potential life are lost as a result of suicides in our nation. The economic burden of suicide is mind-boggling, estimated at almost 12 billion dollars annually in the U.S. (Goldsmith et al, 2002).

Beginning in 1996, the United States has initiated several steps toward establishing a preventive mentality toward suicide, including labeling suicide a major public health problem requiring the

equivalent of a declared war to fund the necessary research and prevention programs at a level commensurate with our stance on AIDS, Alzheimer's disease, etc.

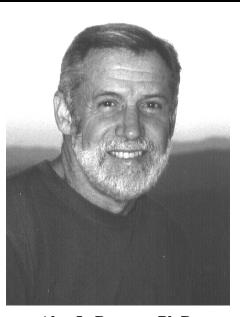
Spurred by survivor-advocates, notably Jerry and Elsie Weyrauch, Georgians who lost their physician-daughter to suicide, and Senator Harry Reid (D-NV) who lost his father to suicide, congressional resolutions were passed declaring suicide a focus of major national concern and a federally-sponsored conference was organized and held in Reno, Nevada to initiate recommendations for suicide prevention. In 1999, then-Surgeon General Satcher published a Call to Action to Prevent Suicide, followed two years later with his far-reaching National Strategy to Prevent Suicide (NSSP). The NSSP systematically laid out 11 goals and 68 objectives that federal and private sector experts believed would significantly save lives. In just the past two years the prestigious Institute of Medicine released a significant scientific report, aptly titled Reducing Suicide: A National Imperative; and just this year the President's New Freedom Commission made suicide prevention the first of its several recommendations to combat the nation's mental health crisis.

With suicide prevention now on the nation's radar screen, leaders in the field are convinced that collaboration among multiple sectors of our society is essential to effectively accomplish these goals. Suicide must be understood as multi-determined, having correlates that range from those biological to psychological, social and cultural, political and economic. Thus, suicide prevention will require collaborative partnerships among mental health and public health specialists, those in criminal justice and faithbased communities, media professionals and legislators, etc.

In a public health approach, the steps toward preventing suicide begin with collecting data and establishing a clear understanding of the problem. To that extent it is important that we understand what we know and what we yet need to learn.

Risk Factors for Suicide and Suicidal Behaviors

Understanding suicide requires us to first understand what makes an individual vulnerable to being suicidal. Suicidologists (those who study suicide) term these characteristics of vulnerability "predisposing risk factors". Predisposing risk factors are both historical and current for any individual. Those that are historical in anyone's life include, for example, having a family history of suicide, violence, or significant mental disorder; early histories of childhood abuse (physical, sexual, and/or emotional); and/or developmental skill deficits that



Alan L. Berman, Ph.D.

make one prone to being socially unskilled, isolated, and lonely at an early age. Current risk factors of significance include having one or more mental disorders, substance abuse, feelings of hopelessness or burdensomeness, having poor impulse control and a low frustration tolerance, rage and aggression. In this regard, it is interesting to note that one Swedish study documented that both adolescents who are bullied and those who were the bullies had higher rates of depression and suicidal ideation. Contributing to risk are having access to a firearm -- used in almost 60% of all suicides, being exposed to suicide by others, and having negative thoughts about one's self, such as being unworthy, unlovable, and un-helpable.

Psychological autopsy studies -- intensive retrospective analyses of the lives and deaths of people who have completed suicide -- have documented rather convincingly that diagnosable mental disorders are present in approximately 90% of all suicides. Most common among these are affective disorders (depression), found in about 60% of all suicides. According to the National Institute for Mental Health, severe depression, i.e., that which includes suicide ideation or attempt behavior that has required hospitalization, carries a lifetime risk of suicide in the range of 6%. That being said, depression is neither a necessary, nor a sufficient condition to understand suicide. Keep in mind that an estimated 40% of those who die by suicide are not depressed. In adolescence, it has been estimated that the ratio of depressed to depressed suicidal adolescents is more than 600:1.

Among adults, alcoholism (in approximately 25%) and schizophrenia (in approximately 10%) are next most frequently associated with suicide. Among younger people, substance abuse (drugs and/or alcohol) and conduct disorders (disorders of behavior that bring youth

into conflict with authority such as the police, get them suspended and expelled from school, etc.) are also common. Anxiety disorders, particularly those involving agitation and severe anxiety, when occurring concurrently with depression, appear to increase risk. In fact, "co-morbidity," the co-occurrence of two or more of a variety of diagnostic conditions, heightens risk for suicide considerably. Thus, schizophrenia is more of a risk factor when there is a co-morbid depressive episode, depression and substance abuse form a more lethal recipe for the potential for suicide, etc.

Why do mental disorders increase vulnerability to suicide? First, they impair an individual's resilience. Second, they amplify feelings of distress. Lastly, they impair coping abilities to deal with - and decrease protections from -- stressful conditions. Mental disorders are associated with greater likelihood of impulsive behavior, lessened ability to think rationally and problem-solve effectively, greater interpersonal conflict and loss, reduced confidence in effectively dealing with stress, thus greater avoidance, etc.

A number of mental disorders are also linked through neurobiological pathways. Low levels of serotonin metabolites, for example, have been associated with higher rates of future suicidal behavior, more lethal suicidal behavior, and other forms of violence, e.g., arson. Genetic factors have been linked to mental illnesses and to impulsive aggression, liabilities which when taken together increase suicidal risk. Suicides do appear to aggregate in some families. Twin studies have found a higher concordance for suicide among monozygotic (identical), versus dizygotic (fraternal), twins. Suicides, also, appear more frequently among biological relatives of adoptees who had completed suicide than among adoptive relatives.

It must be borne in mind that while mental disorders create vulnerability to suicide, the great majority of those with mental disorders do not suicide. Where depression has been significantly related to suicide, hopelessness is an even stronger correlate. Hopelessness is understood as a constellation of negative thoughts about self ("I'm unlovable"), about others ("Nobody cares about me"). and the future ("Nothing will ever change"). Despair and what psychologist Edwin Shneidman called "psychache", an intolerable state of perturbation, push individuals toward wanting to escape their pain.

Once an individual makes a nonfatal suicide attempt, the likelihood of a second attempt and/or a suicide completion increases. About a third of all nonfatal attempts are followed by more suicidal behavior,

see AAS on page 14

Predicting Suicide: A Dilemma Faced By The Treating Physician

By L. Mark Russakoff, M.D. Director of Psychiatry Phelps Memorial Hospital Center



L. Mark Russakoff, M.D.

uicide is one of the most vexing problems that confront mental health providers, patients and their fami-Its occurrence is relatively rare: the suicide rate in the United States remains about 11-12 persons in 100,000. The likely determinants of suicidal behaviors are multiple and interacting. The combination of the rarity of the event and its multiple, interacting contributing factors makes the prediction of suicide extraordinarily difficult. Suicide attempts are much more frequent.

It wasn't until 1952 that the distinction between suicide and attempted suicide was clearly drawn. Until that time, attempted suicide was seen as a bungled suicide. It was noted at that time that the epidemiological characteristics of those who committed suicide were dramatically different than those who attempted suicide: people who committed suicide were typically older white males and people who attempted suicides were typically younger females. The recognition that there were two distinct but overlapping populations at risk led to an exploration of the social context and meanings of suicidal behaviors. It was noted that a significant proportion of people who committed suicide had previously

attempted suicide. The determinants of suicide and suicide attempts differ.

One of the critical tasks of mental health providers is to assess individuals for suicidal risk and to estimate the immediacy of that risk. The determination that a person is at imminent risk for suicide leads to one of the few circumstances in which the rules of confidentiality are relaxed and coercive intervention may occur. If a psychiatrist believes that a person is at imminent risk for suicide, and that intention is a product of a mental illness, then the psychiatrist is ethically obliged to act to prevent such an act. This action might include alerting a family member or significant other to the risk. It might also include calling 911 for an ambulance and assistance in getting a patient to a hospital. Similarly, one of the criteria for admitting a person to the hospital against their will is if they are deemed to be at imminent risk for committing suicide. Kendra's Law, the Assisted Outpatient Treatment legislation, permits the obtaining of court orders to enforce outpatient treatment for persons who have repeatedly attempted to hurt themselves.

However, the assessment of suicidal risk and the prediction of suicide are fraught with problems. There are no characteristics that clearly distinguish those who go on to commit suicide from those who do not. All the tools that have been developed to predict subsequent suicidal acts grossly over-predict the number of people who will do so (that is, identify many more people as suicidal than who truly are) while at the same time underpredict a large portion (that is, miss many people who do go on to suicide). Notwithstanding those problems, clinicians are obliged to perform such assessments and to act accordingly. We will return to this dilemma later.

A number of factors place people at persistent higher risk, others may be protective, and some factors may be related primarily to acute risk. Some factors may be protective against suicidal acts. Strong religious beliefs may exclude suicide as an option to a person. Strong, close connections to family may also mitigate suicidal intent, but when these protections

are overridden by suicidal urges, the survivors often feel guilty or betrayed. Certain situations are more likely to precipitate suicide in a vulnerable individual.

The parameters of assessment include aspects that are cultural and biopsychosocial, which are then impacted by economic factors that involve healthcare reimbursement. Clinical factors that impact risk assessment may be divided into trait and state factors. Trait factors are those which do not change, are enduring. A trait factor has limited utility in clinical suicide prediction since once it is true – the person is male, has a history of depression – it is true forever and places the person at higher, chronic risk. State factors are not fixed, but transient or at least subject to change. Demographic factors strongly associated with suicide include male sex, older age, race, religion - but are of limited utility in that they are immutable factors, best for epidemiological studies.

Social factors, including whether the person is married, recently lost a relationship, recently unemployed, of higher social standing in the community, also contribute to the long-term risk of suicide. Psychological factors include feelings of depression, anxiety - particularly panic anxiety, helplessness, hopelessness and personality style. Diagnosis is a factor, with conditions such as major depression, alcohol dependence, schizophrenia and borderline personality disorder all associated with increased risk. Biological factors have been shown to relate to suicide - low serotonin levels in the spinal fluid. Family studies suggest a potential genetic basis in some cases.

For the clinician, this means that an older, divorced white man, with a history of major depression and alcoholism who presents in the doctor's office is already a high risk for suicide. Although this person is at high risk to eventually commit suicide (from an epidemiological perspective) the actual likelihood that he will kill himself in the near future – no other information being available – is quite low. However, knowing that certain characteristics places an individual at higher risk for subsequent suicide, does alert the clinician to

take extra note of the state variables.

One of the most obvious state variables is the expression - in various degrees - of the wish to die. For persons who either articulate intent to kill themselves or who have made an attempt, there are various parameters that are considered. The degree of intent to kill oneself is assessed through questioning about the articulation of that intent. A person who has just acted on their intent is presumed to have a greater intent than one who is contemplating a similar action. It is believed that a person who has fleeting thoughts of "it's hard to go on" has less intent than someone thinking "life is not worth living," who has less intent than someone who plans "I will go and overdose on my sleeping pills." The dimensions of the articulation of intent include whether the idea is fleeting or impulsive or enduring and shows planning. Additionally, whether the plan is contingent is thought to affect risk, e.g. if my wife leaves me I'll kill myself. Intent expressed in the context of severe depression would be considered as higher risk than intent in someone not depressed (absent other unique features, such as a person threatening suicide if sent to jail).

The availability and type of the intended means also affects risk assessment. The intention of using a gun that one owns is presumed to represent a higher level of intent and risk than the plan to go to another part of the country, purchase a weapon, etc. The plan to use a means that is available and irreversible is seen as representing a higher risk than one that is less available and reversible, e.g. shooting oneself with a gun one owns versus overdosing on pills. One of the interventions that may be made with someone who acknowledges suicidal thoughts is to remove access to the means of suicide, e.g. surrender a gun, have a significant other hold one's medications, etc. Sometimes the inclusion of the significant other in the process helps beyond the fact of the removal of means in that it facilitates communication between the two people regarding the seriousness of the situation.

see Dilemma on next page

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Dilemma from previous page

Healthcare reimbursement practices have clouded the picture of suicide assessment and prediction. Managed care in psychiatry has assumed that inpatient care has been over utilized. Thus the criteria for admission to a psychiatric inpatient facility has typically collapsed into criteria for imminent dangerousness. Whereas in the past admission to the hospital might be for support and relief of psychic pain, including respite from intolerable circumstances, now the criterion that typically determines whether the managed care company will pay for the admission is that the person is in such distress that suicide or other dangerous behavior is likely if the person is not hospitalized. The criterion for admission has moved from that of "medically necessary" to that of "medically essential." Persons sometimes present to the emergency rooms feeling very distressed and realize that they need to assert that they are acutely suicidal in order to have the admission approved.

Clinicians are not mind readers, and subjective report – what the patient says - is typically central to

assessment of suicidal risk. Questions are raised by managed care reviewers about the veracity of statements that a person feels suicidal, putting clinicians in the position of being arbiters of the truth as opposed to healers. Alternatively, clinicians must "see" acute suicidal risk in an individual in order to justify the admission (that both the patient and the clinician feel is appropriate) to the managed care reviewers.

One of the first publications from the Suicide Prevention Center in Los Angeles was titled The Cry for Help. In fact, far more people talk about suicide than attempt or commit suicide. It is quite common for people who subsequently attempt or actually commit suicide to talk about their feelings and concerns before they act. Significant others and family members need to acknowledge such communications and at least offer to explore the person's concerns. Feelings of helplessness often underlie suicide attempts. More often, simple acknowledgement that the person feels so badly is sufficient to alleviate that sense. Unfortunately, feelings of hopelessness often underlie suicides. Hopelessness is a feeling

that implies there is no point in telling others; it is not a matter of "I cannot do it but someone else can" it is a matter of "no one can help me." If the feeling is "no one can help me," then there is no point in sharing one's intentions with others. This discussion of helplessness and hopelessness is drawn as if there is a sharp distinction, with either feeling state very sharply defined. Like most things in life, these states are not so black or white, but appear in shades of gray. Otherwise hopeless feeling individuals often share their feelings with others and provide an opportunity to intervene.

If a person articulates specific thoughts of intention and means, then evaluation by a mental health professional is indicated. helplessness and hopelessness are common in suicidal individuals, assisting the person to obtain such an evaluation is not enabling but potentially life-saving. There are anecdotes about "crying wolf" but would one rather have responded to the cry or regret one's disregard of the cry? This is not to say that there is no room for professional judgments in such assessments, but such decisions are best left to professionals. There are individuals who frequently hurt themselves without the intention or likely risk of dying. These behaviors have been designated as "parasuicidal" and require separate discussion.

The dilemma for clinicians is that they are mandated to be on the alert for suicidal behaviors, have broad clues to suicidal risk but little ability to accurately predict it. If suicidal risk is deemed to be imminent, then the clinician's hands are forced to act to prevent such an outcome. A clinician too sensitive to suicidal risk will pressure many people into higher levels of care than is warranted. A clinician who is insensitive will miss the clues at grievous cost. Because of the inability to accurately predict such behaviors, the best clinician, if he or she treats enough patients, is likely to fail to anticipate a suicide. Clinicians who treat populations at high risk are more likely to have such outcomes than clinicians who shy away from such work. Clinicians strive to develop relationships with their patients so that they work collaboratively towards the goal of recovery without the occurrence of self-destructive acts.

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the majority of these within twelve months of the first attempt. The lifetime risk of completing suicide for those who have made a nonfatal attempt is between 10 and 15%. Some believe that a prior attempt serves as a sort of dress rehearsal, decreasing some of the inhibitory anxiety and self-preservation instinct that sustains most individuals.

Attachments to others for social support are protective factors, decreasing the likelihood of suicidal behavior. Divorce (for men, in particular) and separation (acute losses) lead to higher rates of suicide; being married and having children (for women, in particular) are associated with lower rates of suicide. Family discord and social isolation are associated with higher rates of suicidal behavior; family cohesion has consistently been found to be protective. Attachments to belief systems, for example participation in religious activities (religiosity) provide yet other social attachments as well and protect against suicide.

Socio-cultural conditions are important to understand as they influence suicidal behaviors. Unemployment and economic distress are significantly related to suicidal behaviors. Social change, e.g., modernization and migration, leads to higher rates of economic difficulties for some and alcoholism for others, leading, in turn, to higher rates of

As impulsivity has been significantly associated with suicide, the ready availability and accessibility of a firearm is also a risk factor for suicide. In the U.S. firearms are the most common method of suicide for the young and the old, for males and for females, for whites, blacks, and Native Americans. The CDC has noted that the suicide rate of children under 15 years of age in the U. S. is twice as high as it is in 25 other industrial countries combined; virtually all the difference is attributable to firearms. The risk of suicide of a household member is increased nearly five times when there is a gun kept in the home versus when there is not. In the majority of homes where there is both at least one gun and a child, the gun is kept unlocked, thus accessible for immediate use to suicide.

While we have learned a fair amount about risk factors for suicide, we know far less about warning signs for suicide. Suicides are not readily predictable, even in the immediate near-term. One may be suicidal at some level of potential to act throughout one's lifetime and never act. On the other hand, about a third of nearly fatal suicidal acts appear to have occurred, according to surviving victims, totally on impulse, i.e., within five minutes of the thought or impulse reaching consciousness. Clearly, individuals under conditions of stress and distress who talk of wanting to be dead or threaten to harm themselves must be taken seriously. Vulnerable individuals faced with conditions of shame or humiliation may not overtly communicate suicidality, but surely need to be understood as being at increased risk for suicidal behavior.

American Association of Suicidology

THE FACTS ABOUT SUICIDE

- Suicide is the ninth leading cause of death (2000 data) in the U.S., claiming 29,350 lives per year.
- Suicide rates among youth (ages 15-24) have increased more than 200% in the last fifty years.
- The suicide rate is highest for the elderly (ages 85+) than for any other age group.
- Suicide is preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems.
- Most suicidal people give definite warning signals of their suicidal intentions; but others are often unaware of the significance of these warnings or unsure what to do about them.
- Talking about suicide does not cause someone to become suicidal.
- Four times more men than women kill themselves; but three times more women than men attempt suicide.
- Firearms are the most common method of suicide among all groups (male, female, elderly, youth, black and white).
- Suicide cuts across ethnic, economic, social and age boundaries.
- Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk of suicide and emotional problems.

Risk Factors for Adolescent Suicide: A sampling

- Depression, both unipolar and bipolar
- Drug and alcohol abuse
- Conduct disorder
- Co-morbid disorder
- Borderline personality disorder
- Suicidal ideation
- Suicidal communications, verbal, written, etc.
- Hopelessness
- Impulsivity
- Intense rage; aggressive and violent behaviors
- Social isolation: Withdrawn, isolated, alienated, lonely
- Family history of suicide
- Parental history of major psychiatric disorder or substance abuse
- Family instability and conflict
- Problem-solving skill deficits
- Exposure to others suicidal behavior
- Heightened stress as triggers
- Access to means: Firearm availability and accessibility

What is important to understand is that most people at risk either communicate their intent or are in position to be noticed, observed, and asked questions. Approximately three of every four persons who complete suicide have verbalized their intentions to one or another individuals before acting. The majority of those suicidal have visited their primary care physician within 30 days of their deaths. Sixty percent (60%) of schizophrenic patients were seen by a clinician within 3 days of their suicides. Where we have opportunity to intervene by observing another's behavior, asking about their emotional states, and even directly asking whether they harbor suicidal thoughts, we have the opportunity to intervene and refer them for help.

Early detection and referral are key concepts in preventing suicide. Training "gatekeepers" - teachers, physicians, parents, and others in position to observe and act -- can save lives and is central to models of prevention. But first, we must truly understand and believe that suicide is preventable. And, we have to shed stigmatic attitudes toward suicide so that we may act to save lives.

Is suicide preventable?

Surgeon General Satcher stated unequivocably that suicide is a preventable public health problem. He was right. We have at our disposal a variety of prevention models and examples of successful programs.

Means restriction models focus on reducing access to available means of lethality or reducing the lethality of available means to suicide, thus preventing the impulsive suicide and giving opportunity for intervention. Domestic gas poisoning once was the leading means of suicide in Great Britain. A decrease in the carbon monoxide content of available gas, thus its deadliness (lethality), led to a 15 year decline in the suicide rate in Great Britain after detoxification. Recent legislation in the United

Kingdom limiting the number of pills per packet and the number of packets one could purchase led to a dramatic and immediate decline in paracetamol (their version of acetaminophen) overdose deaths. Bridge barriers on the Ellington Bridge in Washington, DC reduced the annual number of jumps from almost 4 to 0, with no appreciable increase on the immediately neighboring Taft Bridge. States with strict gun control laws have lower suicide rates; states with laws requiring safe storage of firearms have lower rates of firearm suicides.

Early detection, referral and treatment models are effective in detecting and helping those at risk. Hotlines and crisis centers serve as gatekeepers for those in crisis and can effect referrals to community caregivers. School screening programs, similarly, are able to identify and refer those at risk at the time of screening. In the most widely touted of these models, the U.S. Air Force created a service-wide suicide prevention program designed to encourage detection and treatment of at-risk personnel. The consequence of their efforts was a 55% decline in suicide rates.

The National Strategy for Suicide Prevention outlines 11 goals that comprehensively organize what can and will make a difference in the lives of our citizenry. In addition to educating the public to understand what is known about suicide and its preventability and building public-private coalitions to provide leadership and effective management for community and state-based prevention programs, the Strategy recommends:

- Destignatizing mental illness and substance abuse disorders to increase access to treatment by reducing financial barriers, integrating care, and increasing willingness of individuals, especially males, to seek treatment;
- Developing technical support to build capacity for states and institutions, e.g., schools, prisons, youth service programs, to develop comprehensive suicide prevention programs;
- Limiting access to lethal means by educating health care providers and others to reduce their accessibility and improving safety designs and training;
- Educating mental health providers and others (educators, attorneys, correctional workers) and family members to better identify and (clinicians) to better treat at-risk individuals;
- Promoting and supporting the presence of protective factors (problemsolving skills, non-violent conflict resolution skills, etc.); improving primary care screening of risk, etc.
- Reducing structural barriers, e.g., health insurance coverage, to receiving adequate care;
- Improving media portrayals of suicidal behavior to decrease possibilities of imitative behavior and increase proactive behaviors
- Promoting research to evaluate suicide prevention initiatives; and

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If You Are Thinking About Suicide...Read This First

By Martha Ainsworth From the Website: www.metanoia.org/suicide

f you are feeling suicidal now, please stop long enough to read this. It will only take about five minutes. I do not want to talk you out of your bad feelings. I am not a therapist or other mental health professional - only someone who knows what it is like to be in pain.

I don't know who you are, or why you are reading this page. I only know that for the moment, you're reading it, and that is good. I can assume that you are here because you are troubled and considering ending your life. If it were possible, I would prefer to be there with you at this moment, to sit with you and talk, face to face and heart to heart. But since that is not possible, we will have to make do with this.

I have known a lot of people who have wanted to kill themselves, so I have some small idea of what you might be feeling. I know that you might not be up to reading a long book, so I am going to keep this short. While we are together here for the next five minutes, I have five simple, practical things I would like to share with you. I won't argue with you about whether you should kill yourself. But I assume that if you are thinking about it, you feel pretty bad.

Well, you're still reading, and that's very good. I'd like to ask you to stay with me for the rest of this page. I hope it means that you're at least a tiny bit unsure, somewhere deep inside, about

whether or not you really will end your life. Often people feel that, even in the deepest darkness of despair. Being unsure about dying is okay and normal. The fact that you are still alive at this minute means you are still a little bit unsure. It means that even while you want to die, at the same time some part of you still wants to live. So let's hang on to that, and keep going for a few more minutes. Start by considering this

"Suicide is not chosen; it happens when pain exceeds resources for coping with pain."

That's all it's about. You are not a bad person, or crazy, or weak, or flawed, because you feel suicidal. It doesn't even mean that you really want to die - it only means that you have more pain than you can cope with right now. If I start piling weights on your shoulders, you will eventually collapse if I add enough weights... no matter how much you want to remain standing. Willpower has nothing to do with it. Of course you would cheer yourself up, if you could.

Don't accept it if someone tells you, "that's not enough to be suicidal about." There are many kinds of pain that may lead to suicide. Whether or not the pain is bearable may differ from person to person. What might be bearable to someone else, may not be bearable to you. The point at which the pain becomes unbearable depends on what kinds of coping resources you have. Individuals vary

see Read This on page 58





Can Your Community Afford To Not Have **An Assertive Mental Health Education** Program?

> Let Us Help You **Reach Out** To Those **Who Are** At Risk

Personal Journey from page 1

But over the years he had slipped further and further away from us into his ever deepening depression refusing all professional help. A physician who dedicated his entire scientific career to researching the human brain, my father somehow could not deal with the stigma associated with mental illness and his own need for help. And every year his depression would get worse in February during the dark winter months. But by April or May he'd always pull out of it as the days grew longer and he could ride his bike again to work - to his beloved lab at the nearby university. Unfortunately for some reason in the winter of 1983 he could no longer function and simply didn't know how to reach out for help.

My parents were considered public figures because of my father's respected scientific career and my mother served as one of the physicians to Urho Kekkonen, who was president of Finland from 1956 to 1981. Therefore my father's death generated some media inquiries. I don't remember much about that morning but I do recall answering the phone and a reporter asking me to confirm the way my father had died. And I remember saying: "He died by suicide."

The news surrounding my father's death spread fast. And in the days, weeks and months afterward I had to get used to a new label. I became the girl whose father killed himself. I got weird looks at school, I got unsolicited comments from total strangers, and the minister at the church where I had attended for years told me my father was going to hell. All of my father's accomplishments in life had suddenly been wiped out and were now overshadowed by the morbid curiosity about his one last desperate and irrational act. To many the way my father died seemed so much more important than the way he had lived.

I muddled through high school and tried to ignore the label my family had been stuck with. And when it came time for me to go to college I made a clean break and moved literally thousands of miles from the suburbs of Helsinki, Finland, settling in San Francisco where nobody really knew my family history. I finished my studies in three years and got into journalism and thought my painful experience with the stigma associated with suicide and mental illness was behind me.

By 1998 my journalism career brought me to Tampa, Fla., where I was working for a CBS affiliate running its special projects unit and doing longer in-depth pieces. I had been at that station for two years, won an Emmy award for my work and fortunately I had earned the respect of my co-workers. And there on a typical sunny Florida day the stigma of suicide and mental illness came rushing back to my life when a man jumped to his death from a local bridge. What made this man's story different was the fact that he held his dog while jumping. The man died but his pet lived. In the ensuing media frenzy over the dog's recovery and who would get to adopt it from the pound, the man who died was largely forgotten. That bothered me and without a moment's hesitation I shared with my newsroom colleagues for the first time my family history of mental illness and the way my father had died.

At first the silence in the room was deafening. I pleaded for balanced coverage saying this man was one of 30,000 lives lost to suicide every year in the United States – that most people who die this way need help for untreated mental illness. They and their families don't need scorn and judgment and labeling – they are entitled to the same sensitivity and unbiased coverage as the victims of breast cancer and AIDS are afforded by today's news media. This was not just a story about a cute dog surviving a tremendous fall. Luckily my colleagues listened and we produced some very in-depth television news coverage that put the issue of suicide in the context where it belonged without unnecessary sensationalism.

The incident with the man and his dog served as a catalyst for me to apply for a journalism fellowship with former U.S. First Lady Rosalynn Carter at The Carter Center in Atlanta. Mrs. Carter had been an advocate for mental health issues for decades and each year she and her staff selected six journalists from across the nation for an opportunity to research and report on a mental health related subject of the reporter's own choosing. I was awarded the fellowship in 1999 and I ended up spending the next two years putting together "Silent Screams." When it was broadcast in Tampa in June 2001 it had the most viewers in its timeslot. I got hundreds of e-mails and letters thanking me for making the program. The program was nominated for an Emmy Award later that fall and was included in the archives of the Museum of Broadcast Communications in Chicago in 2002.

"Silent Screams" is a compilation of six separate segments covering depression, teen suicide, suicide in the African American community, the Yellow Ribbon suicide prevention program, as well as community activism to reduce suicide deaths. Mrs. Carter also taped a public service announcement for the end of the program. In addition, I interviewed two well-known people about their personal struggles with depression and suicidal thoughts. One was David Smith, whose ex-wife Susan Smith drowned the couple's two young sons in 1994 but first claimed a carjacker had kidnapped her and Michael, 3, and Alex, 14 months. In his extensive interview for "Silent Screams" David told for the first time the entire story of depression and suicide in his immediate family and what role depression has played in his life both before and after the death of his sons and how he learned to cope with it. The other well-known person I interviewed for "Silent Screams" was veteran journalist Mike Wallace of CBS News 60 Minutes. Wallace was one of the first public figures in the U.S. who decided to be open about his struggle with depression. His public disclosure about his condition in an acclaimed HBO documentary "Dead Blue" had absolutely no negative impact on his successful and respected journalism career.

Because of the generosity of the Carter Center Fellowship, I have been able to put "Silent Screams" on the Internet at www.silentscreams.tv. The program has also become a popular suicide prevention education tool and I have literally shipped out thousands of copies of it in the last two years. I still make VHS copies available for educational purposes for \$10. I'm currently working on a DVD version with the Graduate School of Journalism at Columbia University in New York; the school uses "Silent Screams" in its continuing education program.



Former First Lady Mrs. Rosalynn Carter speaking at the Rosalynn Carter Symposium on Mental Health Policy at The Carter Center. Atlanta, Nov. 8-9, 2000. Photo Credit: The Carter Center / Annemarie Poyo

I made "Silent Screams" because I wanted to show that depression is a treatable illness. Had my father been able to reach out for help he'd still be here. "Silent Screams" is dedicated to all those who felt like they couldn't ask for help when they were depressed because the stigma associated with mental health issues stole their ability to speak out. The people interviewed for "Silent Screams" all have one underlying message. "There is no shame in depression or any other mental health condition; it's OK to ask for help, and you can feel better."

I know treatment works. I have a sister who has battled clinical depression for years, even being close to suicide several times. But unlike my father she was able to reach out for help and has benefited from successful treatment. I also know that from my own personal experience. In June 2000 only three weeks after interviewing Mike Wallace I fell seriously ill with a digestive disorder which left me bedridden for three months. This experience also threw me into a situational depression and for the first time I could fully understand what my father had gone through. Fortunately for me I could rely on my sister's advice and her good experiences with her own treatment. I also got help from a completely unexpected source.

It was a Friday night in July 2000 and I was home alone recuperating from my illness. I had just taken my evening medications and felt tired and lonely when the phone rang. It was about 7:30 pm in the evening and I wasn't expecting any calls. I grabbed the cordless phone next to the sofa. The voice at the other end said: "Good evening, this is Mike Wallace and I hope I am not disturbing you."

Wallace was calling to check up on the progress I was making on the interview I had taped with him. He had promised to help me get some footage from CBS News and was simply calling to see if I still needed that footage. When he could not find me in my office it took the great investigative reporter no time to find my unlisted home number. I disclosed my illness and what had happened to me and that the doctors had diagnosed me with situational de-

pression, Wallace grew concerned asking me pointed questions about my treatment and my medications. Calling me from his vacation home in Martha's Vineyard, Wallace spoke for several minutes and offered me his own personal advice. When we finally said goodbye an hour later I had a long list of things he wanted me to ask my doctors and he made me promise I'd let him know how it all turned out.

Ultimately I was not surprised about Wallace's support. He had alluded to his willingness to help others battling depression in the original interview he had granted me about his own illness. And in my case his actions spoke even louder than his words.

Interview with CBS News 60 Minutes correspondent Mike Wallace excerpted from "Silent Screams" (taped May 2000)

Wallace: I do it all the time. I do it all the time.

Hyvarinen: How do you find time to do all that?

Wallace: I find time for this. I do. It doesn't take much to help. If you can just get inside the head of the person who's going through it and persuade that individual it's curable.

Hyvarinen: What does that mean to you?

Wallace: It means a great deal. And you hope with good reason that those individuals whom you have helped find their way out of it and will do the same thing for other folks.

Editor's note: Liisa K. Hyvarinen is a freelance journalist based in Tampa, Fla., working both in print and broadcast. She also teaches journalism at University of South Florida, St Petersburg College and Hillsborough Community College. Her most recent work has appeared in Marie Claire magazine, The Denver Post, Chicago Tribune and Atlanta Journal Constitution. She recuperated from her situational depression and was able to stop taking medications for the illness in June 2002.



The NAMI-NYS Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness. Helpline: 1 800-950-3228 (NY Only) - www.naminys.org - Families Helping Families

By J. David Seay, J.D. Executive Director NAMI-NYS



J. David Seay, J.D.

he view from Albany sees several features on the horizon affecting persons with serious mental illness and their families. They include "Timothy's Law," efforts to restrict access to electroconvulsive therapy (ECT), adult home reform, efforts to restrict access to medications through a "preferred drug list" (PDL) for Medicaid recipients and long-term planning for mental health housing and services. NAMI-New York State's Board of Directors and Government Affairs Committee continue to keep an eye on this horizon as sentinels for New Yorkers with mental illness. NAMI Corner focuses on the first two of those issues.

Sadly, New York remains one of only a small handful of states that continue to allow insurance companies and HMOs to discriminate against persons with mental illness by limiting coverage for mental health services and charging higher copayments, co-insurance and deductibles for such benefits where they do exist. Many consider this discrimination to be a civil rights transgression and an embar-

rassment to a state once proud of it progressivism and compassion toward its most vulnerable citizens. But thanks to the courage and commitment of Tom and Donna O'Clair of Rotterdam, New York, for whose late son Timothy's Law for mental health parity was named, and for the advocacy of Miss New York State Jessica Lynch who has made teen depression and parity in health coverage her platform, tremendous strides have been made in New York this past year toward passage of such legislation.

Miss Lynch and the O'Clairs have joined up with the broad coalition of mental health advocacy organizations across New York - now called TLC for "Timothy's Law Campaign," including NAMI-NYS - and have traveled the state and its media airwaves to personalize this crucial public policy deficit and press for positive change. Senator Thomas W. Libous, chair of the senate's mental health committee, introduced Timothy's Law, which had already been overwhelmingly passed by the Assembly, and garnered no less than 33 majority members as co-sponsors of the bill. And the O'Clairs have met with Majority Leader Joseph L. Bruno to ask that the bill be allowed to go to the floor of the Senate for a vote. They came away from the meeting "cautiously optimistic" that the logiam may soon be broken. NAMI-NYS salutes the O'Clairs, Jessica Lynch, Senator Libous and Majority Leader Bruno for showing courage and doing the right thing for all New Yorkers who suffer from mental illness and their families. Our hats are off to them!

In other developments, there are some subtle efforts afoot to ban the use of electroconvulsive therapy (ECT) in New York for that very small minority of patients who need it. ECT has evolved over the years into a safe and effective – even life-saving at times – medical treatment for some serious and treatment-resistant persons with severe mental illness. Four bills have been introduced and passed by the Assembly that would, in effect, ban access to this treatment which, in the past, has been controversial. One of the

bills was introduced in the Senate this year and it was passed. On its face, this bill seems harmless enough, as it purports only to seek more data about ECT and its use. However, a closer reading of the bill reveals its true intent. Creating a new Article 35 in the Mental Hygiene Law titled "Oversight and Regulation of Electroconvulsive Therapy" – a title that itself is telling - the bill would have defined as "injuries" certain common sideeffects of ECT (such as memory loss and apnea) and require the providers to report themselves to the State as having "injured" such patients. The bill also would have required the reporting of "... any significant changes in medical condition within fourteen days of the administration of such therapy" regardless of whether those changes were caused by ECT. Further, the bill seems to seek only negative outcomes and did not inquire if the patient actually improved or benefited from the therapy, which appears also to belie the real intent behind this information hunt. Lastly, the required reporting would be redundant with the much better-defined reporting already required by the Office of Mental Health from all of its facilities and by the Department of Health's "Statewide Planning and Research Cooperative System" (SPARCS) which covers all Article 28 hospitals, clinics and related facilities statewide.

Governor Pataki, citing NAMI-NYS's concerns, and those of the New York State Psychiatric Association and Greater New York Hospital Association, rightly vetoed this bill. There are efforts to petition the Legislature to override the Governor's veto, and NAMI-NYS adamantly opposes such efforts as illinformed and mislead. In addition to misconstruing the facts about ECT and its present oversight and regulation, for some reason the writers of these petitions also have chosen to misrepresent NAMI's position on these issues and disparage its reputation as an advocate for persons with serious mental illness and their families. NAMI-NYS urges its members and others not to sign such

petitions and to contact their legislators in support of the Governor's veto.

In addition to the above-described technical and public policy flaws of the legislation, NAMI's position and rationale is quite clear and simple: When it comes to this issue, NAMI-NYS stands firmly with science and medicine in its opposition to all efforts to restrict access to or ban the availability of ECT to those few who so desperately need it. ECT is an accepted, safe and effective medical treatment endorsed by the Surgeon General, American Medical Association, American Psychiatric Association, National Institutes of Health and virtually all entities and organizations having credentials and credibility within the psychiatric and scientific communities. Its modern application bears little resemblance to it primitive precursors of decades ago, or even as recently as 10 or 15 years ago. Research has led to a decrease in side effects and an increase in its clinical effectiveness. A recent study by the New York State Commission on Quality of Care for the Mentally Disabled (CQC) examined the administration of ECT around the state. This study found that ECT is being used very circumspectly and selectively and not at all in a runaway fashion or in disregard to patient consent. Opponents of ECT cite a statistically insignificant number of quite dated alleged abuses in their efforts to severely restrict if not outright ban the use of ECT. We are not aware of any responsible study supporting the expressed concern of opponents to ECT that it is being abused or over used. The CQC study found such allegations to be groundless.

The other three issues cited at my column's outset – adult home reform, PDLs under Medicaid and the aching need for serious, fair and balanced long-term planning by OMH and the other agencies involved with interacting with New Yorkers with mental illness – are of no less importance to NAMI-NYS and our legions of family and peer advocates. Indeed these issues will be featured in future NAMI Corners.

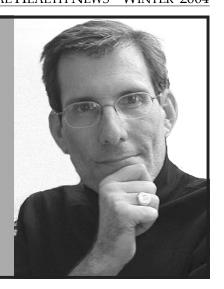
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A Voice of Sanity

A Column by Joshua Koerner Consumer Advocate and Executive Director, CHOICE, New Rochelle, New York



Collaboration Not Coercion

By Joshua Koerner

his is how prejudice works: lots of people are cheap, but when a Jewish person is cheap they're cheap because they're Jewish. Lots of people steal, but when an African-American person steals they've done so because they're African American. Lots of people object to treatment, but when a person with a diagnosis of mental illness objects to treatment it is because of the diagnosis, and so we have the right to override any of their objections and treat them anyway. That's not only prejudice, the belief, but also discrimination, the action.

In my previous column I discussed how nonadherence to treatment was detrimental but commonplace: it can be found in hypertension patients, cancer patients, transplant patients and virtually all other kinds of patients. As far as medication adherence is concerned half of all prescriptions filled are taken incorrectly. There is strong evidence to show that resistance to treatment is a healthy part of a person's attempt to cope with serious illness, even when the pattern of resistance is itself maladaptive. Most tellingly, attempts to override that resistance, by force, tend to lead to even greater resistance, making forced treatment by mental health providers utterly counter-productive.

What is productive? For an answer, I quote from the medical journal Progress in Transplantation: "Techniques such as joining and mirroring prove indispensable in protecting the patient's ego resources while they develop healthier defenses. The critical issue in joining a patient's resistance is that the clinician has to truly believe the patient needs his

defense, no matter how deleterious its impact may be at the moment. If this is not believed by the clinician, the attempt at joining will be experienced by the patient as patronizing and will heighten (not reduce) the resistance".

I have been treated by specialists in internal medicine, urology, endocrinology, and orthopedics, as well as by a prosthodontist, an endodontist and a periodontist. Yet there is no specialty of medicine that has treated me with such consistent patronization, condescension and contempt as has the field of mental health. They don't even bother to hide it: it's like we're not only delusional but deaf, dumb and blind as well.

The first time I was confined to a locked, inpatient unit I was given medication that made me feel like I was going to climb the walls. I could hardly sit still. It was a very uncomfortable, frightening feeling; I had no control of my own limbs. But the unit doctor was convinced it was all due to my anxiety about being discharged. He made no secret of his disregard for what I was saying. When I finally convinced him to take me off the medication I felt better immediately. During episodes with other medications my vision became unfocused, food tasted like metal and I was fatigued and zoned out. No one ever bothered to alert me that these were possible side effects of the medications I was taking. When I reported them I was told I shouldn't worry, they would go away eventually, or that they weren't important given the value of the drug.

After I had been hospitalized a few times it became evident even to my family that I had a high sensitivity to medications. When I was hospitalized in 1986 it was my mother, and not I, who reported this to the attending psychiatrist. But even she was treated with the same condescension, the same attitude of Please Don't Tell Us How To Do Our Job. The result: lithium toxicity, and for the only time in my life I had an episode

of sleep walking which, thought not particularly traumatic for me, was an unwelcome midnight surprise for the female patient whose room I walked into and upon whose floor I urinated.

In light of experiences like this it's understandable that I stopped taking all medications as soon as I was no longer under anyone's direct supervision. I took the drugs whose side effects I knew I could tolerate: pot and cocaine. Of course the result was more hospitalizations but less understanding.

Research states that the feelings of the patient should not be disregarded; that to do so only invites further resistance. Practitioners need to understand why individuals do not want to participate in treatment. They need to address those concerns in ways that validate them. People need to feel they are being understood by their treatment professionals if they are ever to become partners in treatment.

Genuine empathy is in short supply in our current system. It simply isn't a priority. We mental patients are all sick, the providers have all the answers, and if we don't follow their orders...well, there's always Involuntary Inpatient Commitment, Involuntary Outpatient Commitment, and a whole host of other services called Assisted and Assertive which really boil down to one word: Forced.

Self-care requires commitment of a kind other than involuntary. Recovery is a day-by-day, week-by-week, and month-by-month process. It can never be imposed from without; it needs to develop from within. It needs to be internalized. Recovery is more than just making sure someone is taking a certain pill at a certain time each day. Recovery is knowing your triggers, getting enough sleep, eating right. Recovery is both a process and an awareness. It's an awareness that is teachable, but that requires support and validation, not force, and it becomes ever more difficult to accept

support once "support" has been thrust, unwanted, upon you.

The answer is collaboration. As a journal article on cancer screening puts it, "There is a growing body of literature that suggests that engaging patients to participate in the decision-making process may positively influence preventative health behaviors. Shared decision-making involves a two-way exchange of information, in which both the provider and the patient discuss their screening preferences after considering the relative risks and benefits of the different options and then arrive at a joint decision regarding which option to implement. A joint decision, not an imposed decision.

It is so easy to tell someone else to disregard medication effects that include weight gain, or lethargy, or sexual dysfunction. I think that every doctor in residency should be required to take medications that mess them up a little – make them fat and spazzy and soft. It's not the true experience, any more than living in a shelter for a few nights knowing you're going back to your apartment is the true experience of homelessness. But it would be a start.

Even in the absence of direct experience, the disregard of clinicians for the rational desire to avoid these consequences is unjustifiable. Our mental health system is forever paying lip service to evidence-based practices. There is copious evidence that treatment of any kind requires empathy, consideration, partnership, shared responsibility, and open communication. That means sharing responsibility with people who may in some respects be disordered or delusional. I may have thought aliens were coming to transport mankind to a new planet, but I still could recognize when doctors were treating me with contempt. The aliens are gone, but the bitterness toward clinicians remained for a long



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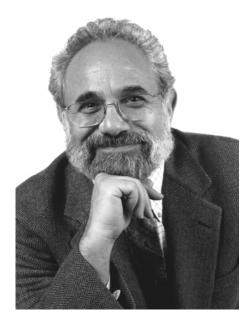
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PONT OF VIEW POINT OF VIEW

Preparing For The Elder Boom

By Michael B. Friedman, CSW



Michael B. Friedman

he mental health system, which currently does not serve most older adults with mental illnesses at all let alone serve them well, is in no way ready for the elder boom, which will hit in force beginning in 2011. Perhaps it's not surprising that there has been so little preparation despite more than a decade of warnings. The big hit will come outside the ordinary five-year planning horizon. But the boom will be so large and will require such extensive restructuring, as well as growth, that preparation cannot responsibly be put off longer.

Here are the facts.

- From 2000 to 2030 the population 65 or over in the United States will grow from 35 million to 70 million and from roughly 13% of Americans to 20%.
- From 2010 to 2020 the growth will be 35%, from approximately 40 million to 54 million.

- Based on current prevalence estimates, from 2000 to 2030 the number of older adults with mental illnesses will grow from approximately 7 million to approximately 14 million.
- Between 2010 and 2020 alone the number of older adults with mental illnesses will grow from approximately 8 million to approximately 11 million.
- During these same periods there will also be a significant increase in the proportion of minority older adults in the United States, rising from 16.5% of the elderly population in 2000 to 25.6% in 2030.

Of course, older adults with mental illnesses are a diverse population. Anxiety and mood disorders are the most prevalent mental illnesses. Dementia becomes increasingly common as people age. Schizophrenia may occur less frequently among older adults than younger adults.² In addition, older adults with mental illnesses exhibit a wide range of abilities and disabilities. Some work, have significant personal relationships, and participate in community activities. Some are unable to manage without substantial supports and/or are extremely isolated

Despite the heterogeneity of the population, there are a number of common issues affecting virtually all older adults with mental illnesses.

- There is a vast shortage of mental health professionals with expertise serving older adults.
- Funding for mental health services is inadequate and discriminatory. For example Medicare reimburses less for mental illnesses than physical illnesses, does not cover prescription drugs, pays for very limited home-based services, and does not cover the kinds of outreach and "wraparound" services that are vital to many people with severe psychiatric disabilities.

- The current service system is, for the most part, structured and financed in ways which assume that people are able to leave home to go for services in specialized settings despite the fact that virtually all providers and researchers report a widespread need for mobile services.
- Most older adults with mental illnesses also have chronic physical illnesses. In part this reflects the fact that older adults are more likely to have chronic illnesses, but in part it reflects an apparent correlation between mental and physical illness. An adequate system must, therefore, address issues of comorbidity.
- For all older adults activity and social involvement appear to be essential to maintaining and/or improving mental health. It is, therefore, critical to promote access to the social mainstream and to integrate mental health services with services provided through the "aging" system.
- Families increasingly regard institutions for older adults as an undesirable last resort. Therefore, in addition to improving services in institutions, it is essential to conceptualize and create community-based support systems for older adults who need them.
- Because families provide most of the supports which older, disabled adults need, it is critical to address the needs of family caregivers as well as those for whom they provide care.
- The rise in the numbers of minority older adults makes it more and more important to develop culturally competent services.
- Research has not yet produced ultimate insights or cures for mental illnesses among older adults. More research is critical.

These are not easy issues to address, and they cannot be addressed without substantial shifts in the way in which we think about the provision of mental health services. It is not just a matter of doing more; it requires doing things differently. It requires understanding that the needs of older adults are as different from those of adults as adult needs are from children's needs.

So it is not as simple as training a large number of geriatric mental health professionals, pressing for more funding to expand services, and expanding research. Finance, research, and the development of a well-trained, highly skilled workforce are all essential of course, but it will also be essential:

- to craft a new vision of service and support, a vision which weaves together the clinical, the rehabilitative, the medical, the social, and the familial,
- to address the fissures in the current structure of serving older adults and to bring together mental health, health, and aging systems

Given the magnitude of other issues confronting the mental health system, it is easy to understand why little work has been done to begin to shape a system of care of older adults with mental health problems. But the march of demography is ineluctable. We must act now or face a vast crisis in the not too distant future.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and of Westchester. The Center has recently begun a project to advocate for improved geriatric mental health policy. For further information e-mail Mr. Friedman at center@mhaofnyc.org.

Footnotes:

¹ Estimates are from the U.S. Census Bureau

Send a Message of Hope to Someone in Need With a Subscription to Mental Health News: See Page 59

² Surgeon General's Report on Mental Health

the NARSAD report

The National Alliance for Research on Schizophrenia and Depression

By Constance E. Lieber, President NARSAD



Constance E. Lieber

The Warning Signs Of Suicide

t is estimated that there are more than 31,000 suicides every year in the United States – about 11 out of every 100,000 people. This number breaks down to about four suicides per hour, and it is estimated that an attempt is made about once a minute. The true numbers are probably much higher because many suicides are reported as accidents or illnesses. Suicides are usually the result of a complex combination of emotional, social, and biological factors.

What Causes Suicide?

Most suicides happen in depressed people. Depression is not just a passing blue mood that lifts in a few hours or even a few days. It is a sadness that will not go away and that interferes with everyday life.

Approximately 30 percent of clinically depressed people attempt suicide.

- 1. Feelings of despair and hopelessness (signs of depressive episodes) are the most common motives for committing suicide.
- 2. Most depression-related suicides occur during a patient's first three depressive episodes.
- 3. Otherwise ordinary events can trigger depressive episodes that could lead to suicide. Such experiences may include illness, humiliation, unrequited love, losing money or a job, a serious domestic quarrel, the collapse of a marriage, or a death in the family.
- 4. When properly diagnosed, more than 80 percent of people suffering with depression can be successfully treated.

Contributing Factors to Suicide

There are many conditions that may cause people to have suicidal thoughts, such as complications with marriage, occupation, social class, religion and health. Other contributing factors include:

- Alcoholism plays a role in 30 percent of all completed suicides.
- Firearms are now used in more suicides than homicides.
- People with AIDS have a suicide risk up to 20 times that of the general population.
- Clustered suicides account for 1-5 percent of all teen suicides in the United States.

Teenage Suicide

Similar to suicidal adults, suicidal youths are almost always severely depressed. However, the signs of depression are harder to recognize in youngsters and adolescents because their sadness and despair are usually manifested as boredom, apathy, hyperactivity, or physical illness. Since youths do not have the life experiences of adults, they may react intensely to seemingly trivial frustrations.

To better identify the teenagers at risk for suicide, a Columbia University researcher, Dr. David Shaffer, has developed a new method to screen adolescents for depression and suicide risk. The new measurement is based on a profile generated through computer "diagnostic interviews," followed by treatment under psychiatric care. Testing has shown that young people suffering depression and pre-suicidal mood disorders will identify themselves to the computer.

Children and teenagers are also more

susceptible to suicide epidemics, which account for between 2-5 percent of all suicides annually. Vulnerable youngsters exposed to stories or lyrics rich with suicide imagery or allusions are more susceptible to suicide.

Late-Life Suicide

An increasing suicide rate in older Americans is a major clinical problem. While people over the age of 65 make up only 13 percent of the population, they account for 25 percent of all suicides. White males over the age of 85 have the highest suicide rate of all Americans – six times the current overall national rate. Almost all suicides by older Americans involve non-psychotic, non-bipolar depression in people who are not substance abusers. This is the most treatable form of depression.

- Approximately 15-20 percent of people 65 years of age and older, in the United States, suffer from depression, but less than half are receiving treatment.
- Each year more than 6,300 older adults take their own lives approximately 17 a day.
- 75 percent of older suicide victims have been seen by their primary care physician during the month preceding their death.

Gender and Suicide

Although twice as many women as

see NARSAD on page 58

NARSAD RESEARCH

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The Lieber Prize For Schizophrenia Research Robin S. Murray, M.D., D.Sc., Institute of Psychiatry, London The sum of his research has led to fundamental insights about the importance of early brain development in Schizophrenia, making landmark contributions to the understanding of risk factors.

The Nola Maddox Falcone Prize For Affective Disorders Research

Robert M. Hirschfeld, M.D., Univ. of Texas Medical Branch, Galveston Ross J. Baldessarini, M.D., Harvard University Leonardo Tondo, M.D., Harvard University

Dr. Hirschfeld is an innovative leader in the early identification and treatment of bipolar illness built on his pioneering studies of affective disorders. Drs. Baldessarini and Tondo have provided unique insights into bipolar illness and the ability of lithium to improve and prevent manic depressive episodes and decrease suicidality.

The Ruane Prize for Child and Adolescent
Psychiatry Research

Leon Eisenberg, M.D., Harvard University

A leader in Child Psychiatry for over 40 years, spanning pharmacological trials, neurological and psychological theories of autism and social medicine from research to teaching and social policy.

The newly inaugurated
Dr. Patricia S. Goldman-Rakic Memorial Prize for
Achievement in Cognitive Neuroscience
Solomon H. Snyder, M.D., Johns Hopkins University

A pioneer in the study of brain receptors, discoverer of the role of nitric oxides as a class of neurotransmitter in the brain and techniques for understanding and manipulation of neurotransmission receptors.

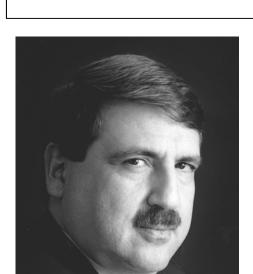
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The NYSPA Report



Jack Drescher, M.D.

Gay, Lesbian and Bisexual Mental Health

By Jack Drescher, M.D., Chair APA Committee on GLB Concerns

n 1948, Alfred Kinsey's landmark scientific study revealed the normal range of human sexual diversity to be wider than previously imagined. Kinsey's Report eventually paved the way for greater acceptance of gay, lesbian and bisexual (GLB) people, today estimated to number between three and fifteen million Americans, or 1-5% of the population.

Determining the mental health needs of this enormous population has been complicated by historical factors. Homosexuality, once considered a mental illness, was removed from the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM) in 1973. Where once homosexuality's treatment of choice was unsuccessful efforts to change it, today's focus is on the mental health needs of an increasingly "out of the closet" GLB population. Some GLB mental health concerns are briefly addressed below.

Coping with Stigma

Mental health issues affecting GLB populations often resemble those affecting heterosexual populations: developmental issues associated with adolescence, psychological responses to medical illness, problems of aging, relationship issues, family difficulties, or coping with a psychiatric disorder. However, the stigma associated with being gay, lesbian or bisexual can, in many cases, either exacerbate pre-existing psychiatric problems or affect the general mental health of non-psychiatrically disturbed individuals.

A normal part of living in a hetero-

sexual world requires hiding one's homosexuality, colloquially referred to as "being in the closet" or "closeted." Antihomosexual attitudes are common and reasons to hide are numerous. For example, families usually do not want to accept or even know that their children are gay. Gay kids learn early on not to let anyone know, for fear of being teased, ostracized or even physically attacked. However some gay kids, those known as sissy boys or very masculine tomboys, cannot hide and become targets. Tragically, recent studies show gay male adolescents may be three times as likely to attempt suicide as their heterosexual peers. Stigma, which makes it difficult for gay adolescents to discuss their early sexual feelings, is a probable contributor to this high figure. It is vital that mental health services for GLB adolescents reflect awareness of antihomosexual bias by providing accepting therapeutic environments for them that do not further add to the stigma or trauma they have already experienced.

Stigma is not limited to adolescents. Many GLB adults may be selectively "out" in certain social settings, but not to everyone in their lives. Those who hide from their families, friends, physicians, or even their therapists, are less likely to openly discuss and address their physical and mental health needs. In addition, many GLB individuals, seeking treatment from health care personnel have been subjected to antihomosexual bias. Fear of stigma and actual antihomosexual attitudes of health care personnel often result in underutilization of services by GLB adults.

Coming Out

Many GLB individuals struggle with the issue of whether to reveal their sexual identities to others. "Coming out" or "coming out of the closet" may be the most commonly shared cultural experience defining the modern gay identity. In everyday usage, this means telling another person that one is gay. However, the process is not just about revealing oneself to others. For in coming out, a person attempts to integrate dissociated aspects of the self, to unlearn the stigmatizing stereotypes of homosexuality, and to learn the ways of the lesbian and gay culture they are entering.

The complex process of coming out involves both internal and external dimensions and can lead to increased comfort with one's own feelings. Greater ease in expressing one's feelings, both to oneself and to others, can lead to enrichment of work and relationships. Parents and mental health professionals should seriously consider the special needs and vulnerabilities of GLB adolescents who are first coming out. As GLB people repeatedly face moments in which they have to decide whether or not to reveal themselves, coming out is a potentially ongoing and unending process.

Inclusive Clinical Settings

GLB patients are usually treated alongside heterosexual peers in inpatient, outpatient, and residential clinical settings. In recent years, a few specialized units have developed for working with GLB persons--either community health centers serving the needs of the local GLB communities or units geared to particular problems like HIV infection or substance abuse. Whether services are provided in general or specialized settings, staff are trained about the special concerns of the GLB population and to provide them with sensitive and unbiased care.

The clinical setting and staff are important determinants in creating a climate of inclusiveness for GLB patients, as explicit and implicit communications of acceptance promote successful psychiatric treatment. For example, the language and behavior of psychiatrists and other staff should convey that they do not presume all individuals or families are heterosexual. Inquiries about relationships or the gender of a patient's partner should be open-ended and nonjudgmental. Gay-friendly publications in the waiting area and self-reporting forms for patients that neutrally inquire about sexual orientation and family arrangements can help reassure a GLB person--as well as those uncertain about their sexual orientation--that they can talk openly about their concerns.

Another important approach with GLB patients is to routinely include,

when appropriate, references to significant friends and members of nontraditional families during evaluation and treatment.

When necessary, same-sex partners and children in these families should be involved in the GLB patient's care. For example, it may be important to obtain corroborative information from partners, to identify potential sources of a patient's problems within the context of the couple or family, or to include a partner in maintaining compliance. In addition, issues of confidentiality and decision-making in working with heterosexual families should also apply to working with GLB families.

Dr. Drescher is Chair of the American Psychiatric Association's Committee on Gay, Lesbian and Bisexual Concerns, author of Psychoanalytic Therapy and the Gay Man (1998, The Analytic Press) and Editor of the Journal of Gay and Lesbian Psychotherapy.

Further Readings

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Duberman, M. (1991), Cures: A Gay Man's Odyssey. New York: Dutton.

Savin-Williams, R.C. (2001), Mom, Dad, I'm Gay: How Families Negotiate Coming Out. Washington, DC: American Psychological Association.

The preceding "NYSPA Report" deals with the mental health concerns of Gay, Lesbian, and Bisexual persons. It is one of a number of articles which will appear in this space from time to time addressing the special mental health issues of a variety of groups.



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Lessons Learned After Suicide

By Megan Castellano, Director MHA in Putnam County



Megan Castellano

can still remember the phone call as if it were yesterday, even though it's now been four years since that awful day. My friend committed suicide and while I still have difficulty wrapping my mind around this reality, it has slowly gotten less painful. It was June of 1999, my friend had struggled

her whole life with depression, self injurious behavior and numerous hospitalizations as a result. I remember when I met her, the scar on her neck made me wonder what her life had been like and what would make her want to do such a thing. I had a lot to learn. I had just taken a job as the Service Director of an agency that provides community support services for mentally ill adults. I had no experience with the mentally ill. My prior job was in a clinic that specialized in treating children and families. This new job I thought would be a wonderful career opportunity and another chance for me to help people. I had no idea how much I would learn from the consumers at our agency and what they would do to help me.

I soon got a crash course in consumer empowerment and what that meant for people in recovery. As I became familiar with my new duties, I immediately connected with a young woman who was a leader, admired, loved and respected by her peers and ready willing and able to do whatever was needed to help other consumers, through the agency's services and in her own private life. Her name was Renee. She would bubble with sunshine and had the energy to handle

see Lessons on page 56



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By Joseph A. Glazer President & CEO, MHANYS



Joseph A. Glazer

Mental Health at a Crossroads

eights of attention this great have not been focused on mental health in twenty-five years – since Willowbrook.

President Bush has released the "New Freedom Commission Report" on the state of mental health treatment in America. The report has been traveled around the country, well-presented by one of its authors. The document clearly outlines where America is today in meeting the needs of people living with mental illnesses. Such an effort, coming from the highest office in the land, draws needed

attention to our issues.

But, here is the crossroads: The report simply substantiates what we already know. America's mental health service delivery system "is fragmented and in disarray." The gaps are bigger than the system. Our mental health structure is failing the people it serves, and they are

falling through the cracks, landing on the street, in emergency rooms, jails, prisons and morgues.

We live in a climate of diminished employment for Americans, government revenue shortfalls, a shift away from government responsibility for our neediest and most vulnerable people. Oh, and don't you know there is a war on?

So, the need has been recognized and outlined, but at a time largely bereft of receptivity. The cry is loud, but so few decision makers want to hear it.

We can secure passage of legislation eliminating health insurance discrimination in neither our federal Congress nor our State Senate. Our prison and jails are filled with people with serious mental illnesses – in the same proportions people filled our state run psychiatric hospitals 45 years ago.

The Reverend Dr. Martin Luther King, Jr., said, "Riots occur not at the point of greatest despair, but at the point of greatest hope." At our mental health crossroads today, it seems those points have converged.

Where will this path lead? Will we pass Timothy's Law? Will we extract our folks who are caught in the criminal justice system? Will people have access to the care and treatment they need? Will recovery become a realistic goal for all who seek it?

As the calendar turns, we embark on another year of government in session. We certainly have our work cut out for us. But we also have information and support from the highest level of government, and the potential to make leaders hear us. Next year is an election year – for state legislators, members of Congress and the President.

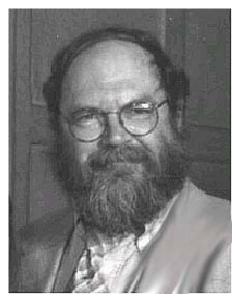
The future of our efforts lie between despair and hope, apathy and riot. The roadblocks along the way are formidable, but as 2004 approaches, we at MHANYS find ourselves re-energized and prepared to move forward. We appreciate knowing that you will continue to work beside us as we head down the road, looking to make our world a better place for the people we are, love and serve.

Mental Health News Wishes to Express
Its Sincere Gratitude And Appreciation
To Our Faithful Readers,
The Members Of Our Advisory Council,
And The Organizations and Supporters
Who Make This Publication Possible

WORKING WITH MEDICATIONS

Do Medications Make People Fat?

By Richard H. McCarthy M.D., C.M., Ph.D. Comprehensive NeuroScience



Dr. Richard H. McCarthy

n the past few years, the issue of weight gain has become quite important in society in general and very much so in psychiatry. As is often the case, problems that are common in society at large, are magnified within the mentally ill community. Patients can and do gain weight while taking medications. The question is are the medications causing people to gain weight, and if not, why does this occur?

Even though it seems simple, it is not so easy to decide if a medication causes weight gain, and if that weight gain is bad. In many psychiatric illnesses, weight loss is a symptom. This is not true just for those with eating disorders. Weight loss is a typical symptom of depression. Manic patients can burn off amazing amounts of weight in the course of a manic episode and weight loss is frequently found in psychotic disorders as well. As these patients improve, their weight goes back up to what it had once been

A better way to discuss weight gain would begin not so much as to whether it occurs, but whether the weight gain is desirable or undesirable A return to normal weight in a depressed patient who is recovering is desirable. Continued weight gain above and beyond what they had been before the onset of their episode of illness is usually considered to be undesirable. The desirable weight gain has less to do with the medication and more to do with recovery. The undesirable weight gain may be related to the medication or to recovery. It's sometimes hard to tell. Unfortunately, studies that are used to determine

whether a medication works and what its adverse effects are rarely distinguish between desirable and undesirable weight gain. As a result, every medication that effectively treats an illness, where weight loss is a symptom, will also list weight gain as an adverse effect. Another difficulty with the distinction between desirable and undesirable weight gain is who decides. I have yet to meet a patient with an eating disorder who regards a return to normal weight as desirable. Likewise, I have had some paranoid patients that eat to purposely put on large amounts of weight. They seek to become large, if not huge, because they feel that if they are large (big and fat) then they will be invulnerable to the attacks of those whom they believe wish to hurt them. They are confusing "big and fat" with "big and strong". These patients would say that their weight gain is desirable, when it is really a symptom of continued illness rather than of any recovery.

The most frequent explanation that I hear from my patients is that the medications slow down their metabolism. As a result, they are gaining weight even though they are dieting and are very careful about what they eat. Unfortunately, it is extremely rare for psychiatric medications to slow down one's metabolism to this degree. The problem is more often not that our glands are being slowed down, but that we are eating more than we think we are eating. When I ask people to record what they eat and add up the calories, it is almost always the case that they are taking in far more than they think they are. People, not just the mentally ill, often under report their food intake and only become aware of just how much they are eating when they actually count calories. Moreover, people often confuse "fat free" with "low calorie". These are quite different. It is not unusual for a "fat free" food to have more calories than the regular food. Thus, people may think that they are dieting with fat free when they are really overeating. When people say that they gain weight because of a gland problem they are partially correct. The major gland that is responsible for gaining weight is the "mouth gland." My patients and I gain weight and get fat for the same reason; we eat more than we burn off through exercise. What is different for people taking medications is that they often want to eat more and they frequently exercise less.

It is not entirely fair that people taking medications for their mental illnesses have more to struggle against than everyone else. Almost all psychiatric medications, especially all those medications used to treat psychosis, will increase an

individual's desire to eat. Likewise, some of these medications also increase a patient's appreciation for things such as sweetness. Thus, people taking such medications may want to eat more and may enjoy what they eat more than the rest of us. So, for example, a person taking their medication can feel hungrier, enjoy food more and, as a result, eat more. The medication did not cause the weight gain, eating did. An increase desire for food does not necessarily lead to weight gain. Certainly, not all patients with such an increased desire gain weight. If this person does not eat more sweet foods, he will not gain weight, no matter how good it tastes. This is quite similar to the kind of difficulty we all face. Chocolate tastes good but if we eat too much of it, we will all gain weight. The problem for people taking medication is that it may actually be harder for them to fight their increased desire.

It may also be that patients gain weight in different places for different reasons. A friend of mine began to look into this issue of weight gain and found that his patients only gained weight when they were re-hospitalized. In fact, patients on average gained ten pounds every time they were hospitalized. As outpatients their weight tended to remain stable. While they did not gain, they also did not lose the hospital acquired weight. Therefore, their weight went up every time they were hospitalized. What was happening in the hospital that would lead to such significant gains in weight? In general, it has been my observation, that patients are overfed in the hospital. This overfeeding has three separate sources. First of all, the patients themselves will often seek treats such as soda and candy and obtain them more often than they would have on the outside. This may be due to boredom as much as anything else. I have never been to a hospital that did not have a candy and soda machine that patients could use. Secondly, visitors often bring food to give to the patient in an attempt to help the person feel better. Food feels nice, and people in the throes of a hospitalization have little else that is nice in their lives. Thirdly, hospitals often over feed patients. Hospitals allow patients either almost unlimited food or inordinately large portions. In the past, every time that I proposed that the hospital place some kind of a limit on the amount of food a patient could get at lunch, the proposal was turned down. I routinely saw patients eating two main course and three deserts for lunch. In some hospitals, it is argued that "second helpings" are a patient's right and any attempt to limit them is an attempt to deprive an individual of his rights. It is difficult for

me to see how fostering obesity by medical personnel can be construed as a patient right. Indeed, hospitals are required to perform nutritional assessments and to feed patients accordingly. Thus, patients with diabetes should not receive diets high in sugar. Likewise, patients who are obese or gaining significant amounts of weight, should not be given access to unlimited amounts of food. This failure to limit the amount of food made available to patients is a source of frustration for the family and the physician. Later it is a problem, if not a health hazard, to the patient.

As outpatients, people can gain weight because they have a terrible diet. In the programs that they attend and the residences where they live, it is common for patients to be eating large amounts of not just fatty, fried foods but also foods high in carbohydrates. Similarly, people often underestimate the significance of fairly minor additions to the diet. One extra can of soda per day can lead to a ten pound weight gain in a year. The small pleasures of life, such as a candy bar, are readily available, cheap and fattening. For those patients whose illness carries with it an impairment in the ability to experience pleasure, such minor treats may be the easiest and only pleasure that they can find in a day. It is hard to lose weight with a diet high in fats, carbohydrates and fried food. However, these foods are easy to obtain and almost always cheaper than those foods that are necessary for a healthy, weight reducing diet. Fruits and vegetables are much more expensive than pasta. To some extent, the inadequate diets of outpatients is due not just to the decisions about food made by the patients and staff, but also to the amount of money made available for this purpose. Poorly funded programs will feed patients poorly and the programs outside the hospital that house and treat the patients are poorly funded.

Weight gain occurs in everybody when the daily caloric intake is greater than the amount the person burns off. In patients who are sedated, it is not surprising that exercising goes down. It is possible for medications to sedate people such that they exercise less and in this way medications may very well lead to weight gain. The solution here is for the individual to seek less sedating medication and/or to increase activity.

Blaming all weight gain on medications is as silly as expecting medications to completely solve all of the person's problems. Medications alone do not lead to recovery. Hard work does. Medications alone do not make you fat. Over eating and under exercising does.

AAS from page 14

 Improving and expanding surveillance systems to better identify risk factors and protocols for data collection

How is the AAS leading the effort of prevent future suicides?

The American Association of Suicidology (AAS) was founded in 1968 as a national/international membership organization committed to better understand and prevent suicidal behaviors. As the oldest of national non-profit organizations, AAS has a storied history in the field of suicidology. It publishes a highly respected peer-reviewed journal (Suicide and Life-Threatening Behavior) in the field, presenting state-of-the-art research on suicide and evaluations of prevention programs. It informs the public and the professional communities of current national and international developments through a quarterly newsletter (Newslink) and publishes yet a second newsletter written solely by and for survivors of suicide (Surviving Suicide). In addition, for the past 35 years AAS has administered an annual conference for mental health clinicians and researchers, public health professionals, survivors, and front-line crisis workers and crisis service professionals, offering intensive training opportunities and state-of-the-art research updates.

Moreover, the AAS has established leadership positions by:

- advocating for the National Violent Death Reporting System, now housed at the CDC to better collect data regarding suicidal and homicidal-suicidal behaviors;
- developing recommendations to prevent youth suicide by firearms; recommendations to inpatient psychiatric services regarding discharge disposition planning for suicidal patients and their families;
- conducting studies designed to increase help-seeking behavior among suicidal males;
- publishing collaborative recommendations for the media reporting of suicide;
- defining research-based recommendations for the identification and dissemination of appropriate public health messages, e.g., on the Warning Signs of Suicide;
- collaborating on research projects in the states of Nevada and Alaska which have led the nation in suicide rates. The AAS is currently working with colleagues in Alaska to intensively study and profile all suicides in the state in the last year;
- training thousands of mental health professionals in risk assessment and treatment protocols for working with at-risk individuals;
- developing core curricula for state and community suicide prevention task force and committee personnel to better form effective coalitions to prevent suicide on local levels; de-

- veloping training curricula for mental health professionals.
- developing training materials for the U.S. Army's and the Department of the Navy's suicide prevention programs:
- certifying and networking crisis hotlines into a 1-800-SUICIDE national crisis intervention system and evaluating the process and outcomes of telephone hotline interventions;
- providing supportive resources and directories of support group services for survivors of suicide;
- developing recommended protocols and interventions to prevent suicide in correctional systems;
- networking clinician-researchers and public health professionals with survivors and others to constantly improve systems of care and intervention with at-risk individuals, etc.

What are our greatest challenges? What lies ahead?

Suicidology is a young field (only slightly more than 100 years old as a "scientific" area of inquiry). As it took more than 200 years to eradicate smallpox, the cause of that was a single viral entity, we have a great deal to yet learn about such a complex problem.

From a research perspective we need to implement large-scale prospective studies of at-risk individuals. We need to no longer exclude the most at-risk individuals from randomized clinical trials of new interventions. We need greater emphasis on outcome evaluation studies of prevention initiatives. We need a better understanding of why pharmacologic interventions work for some, but not others. We need to better understand pathways of psychological pain and mechanisms for helping people better tolerate and cope with such aversive experiences.

From a public health perspective we need to better educate the public that suicide is much more complex than simply an outcome of depressive illness. We need to understand better how to motivate men to seek and accept receiving help. We need to better educate families that a gun in the home is much more a threat to those that live in that home, particularly youth, than it is a deterrent to unwanted intrusion. We need dramatically increased infusions of federal and private funding to wage "war" on suicide. We need to reduce barriers to effective treatment, particularly managed care controls on covered systems of care and parity in insurance coverage for underlying mental disor-

Clinically, we need to develop a range of new and creative models of intervention. We need to better train clinical and primary care professionals to assess risk and treat (or refer for treatment) at-risk individuals. We need to better treat individuals to contain aggression, tolerate frustration, regulate painful emotions, and cope with hurtful experiences. We need better attention to continuity of care. We need to listen better to suicide survivors as they share their experiences with clinical care systems.

see AAS on page 42



American Association of Suicidology

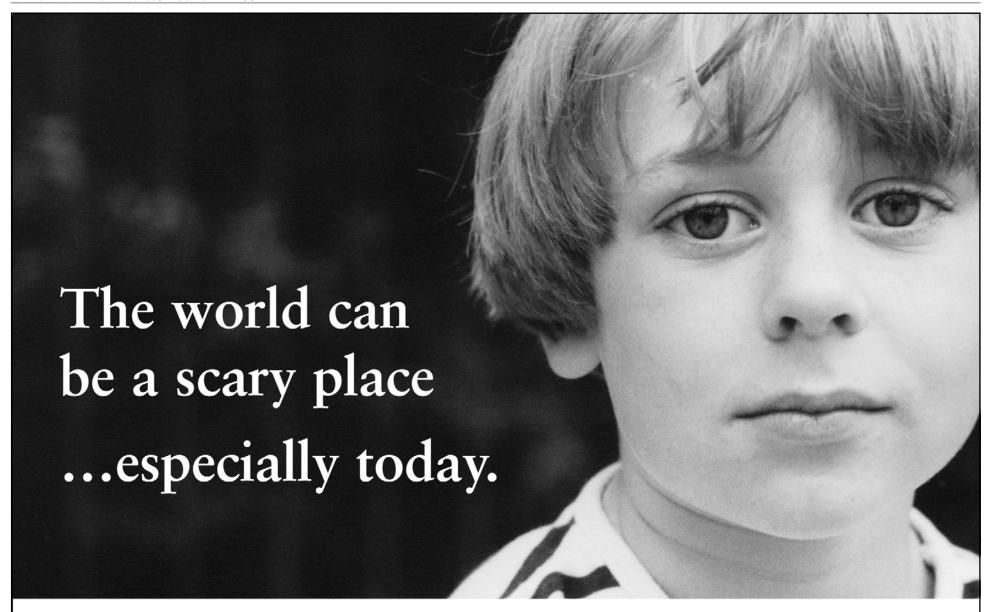
ELDERLY SUICIDE FACT SHEET

- While the elderly make up only 12.6% of the population, they account for almost 18.1% of the suicides.
- There is one elderly suicide every one hour thirty-nine minutes.
- The suicide rate for the elderly rose 9% between 1980 and 1992. During that rime, there were 74, 675 completed suicides of persons over 65. Rates have declined since that time.
- In 2000, suicide rates ranged from 12.6 per 100,000 among persons aged 65 to 74, to 17.7 per 100,000 persons aged 75 to 84, which is nearly double the overall U.S. rate.
- White men over the age of 85 are at the greatest risk of all age-gender-race groups. In 1999, the suicide rate for these men was 59.6 per 100,000. That is nearly 6 times the current overall rate.
- 84% of elderly suicides are men; the number of men's suicides in late life is 5 times that for women (men's rates are 7.6 times those of women).
- The rate of suicide for women declines after age 60 (after peaking in middle adulthood, age 40-54).
- Although older adults attempt suicide less often than those in other age
 groups, they have a higher completion rate. The elderly are more lethal in
 their attempts and complete suicide more often. For all ages combines, there
 is 1 suicide for every 20 attempts. Among the young (15-24 years) there is 1
 suicide for every 100-200 attempts. Over the age of 65, there is 1 suicide for
 every 4 attempts.
- Firearms are the most common means of completing suicide among the elderly. Men (78%) use firearms more than twice as often as women (35%).
- Alcohol or substance abuse plays a diminishing role in later life suicides.
- Contrary to popular opinion, only a fraction (2-4%) of suicide victims have been diagnosed with a terminal illness at the time of their death. Two-thirds of older adults in their late 60's, 70's and 80's were in relatively good physical health when they died by suicide.
- 20% of elderly suicides over 75 have been seen by a physician within 24 hours of completing suicide; 35% have been seen by a physician within a week; 75% have seen a primary care physician within a month of their suicide; and 80% have seen a primary care physician within 6 months of their suicide.
- 66%-90% of elderly suicides have at least one psychiatric diagnosis. Twothirds of these diagnoses are for late-onset, single episode clinical depression.
- As many as 75% of depressed older Americans are not receiving the treatment they need, placing them at an increased risk of suicide.
- Elderly persons are less likely to reach out by calling a crisis line than their younger counterparts.
- Suicide rates are highest in the mountain states of the United States for the nation as a whole and the elderly.

MYTHS:

- 1. Depression among the elderly is a normal consequence of aging and associated problems.
- 2. Depression among the elderly cannot be treated.
- 3. Most completed suicides are terminally ill.
- 4. Elders who complete suicide do not have close family members.
- 5. Only elderly persons who live alone are at risk for suicide.
- 6. Suicide and suicidal behavior are normal responses to stresses experienced by most people.
- 7. There is nothing that can be done to stop an elderly suicide.
- 8. Most suicidal elders will self-refer to obtain mental health care.
- 9. Suicidal elderly do not exhibit warning signs of their suicidal ideation or intent.
- 10. Adverse living conditions are not significant risk factors in elderly suicide.

In this fact sheet, elderly refers to persons over the age of 65. Information presented refers to the latest available data (i.e., 2000 data).



If you or someone you love is feeling overwhelmed by fear or sadness, make the call that can help. Saint Vincent Catholic Medical Centers offers a full continuum of mental health and chemical dependency services from individual counseling to inpatient care and residential services.

We have specialized programs for persons with serious mental illness and for individuals with developmental disabilities. Bilingual, bicultural treatment services are available in Spanish. And we treat all ages, from children to mature adults.

Find out why more area residents choose St. Vincent's. Get help today.

Call 888-689-1684 24 hours, seven days a week



NIMH from page 1

or sexual abuse; firearms in the home; incarceration; and exposure to the suicidal behavior of others, including family members, peers, or even in the media.

Gender Differences (Chart Below)

Suicide was the 8th leading cause of death for males and the 19th leading cause of death for females in 2000. More than four times as many men as women die by suicide, although women report attempting suicide during their lifetime about three times as often as men. Suicide by firearm is the most common method for both men and women, accounting for 57 percent of all suicides in 2000. White men accounted for 73 percent of all suicides and 80 percent of all firearm suicides.

Children, Adolescents, and Young Adults

In 2000, suicide was the 3rd leading cause of death among 15- to 24-year-olds-10.4 of every 100,000 persons in this age group-following unintentional injuries and homicide. Suicide was also the 3rd leading cause of death among children ages 10 to 14, with a rate of 1.5 per 100,000 children in this age group. The suicide rate for adolescents ages 15 to 19 was 8.2 deaths per 100,000 teenagers, including five times as many males as females. Among people 20 to 24 years of age, the suicide rate was 12.8 per 100,000 young adults, with seven times as many deaths among men as among women.

Older Adults

Older adults are disproportionately likely to die by suicide. Comprising only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000. Among the highest rates (when categorized by gender and race) were white men age 85 and older: 59 deaths per 100,000 persons, more than five times the national U.S. rate of 10.6 per 100,000.

Attempted Suicides

Overall, there may be between eight and 25 attempted suicides for every suicide death; the ratio is higher in women and youth and lower in men and the elderly. Risk factors for attempted suicide in adults include depression, alcohol abuse, cocaine use, and separation or divorce. Risk factors for attempted suicide in youth include depression, alcohol or other drug use disorder, physical or sexual abuse, and disruptive behavior. As with people who die by suicide, many people who make serious suicide attempts have co-occurring mental or substance abuse disorders. The majority of suicide attempts are expressions of extreme distress and not just harmless bids for attention. A suicidal person should not be left alone and needs immediate mental health treatment. Adverse life events in combination with other risk factors such as depression may lead to suicide. However, suicide and suicidal behavior are not normal responses to stress. Many people have one or more risk factors and are not suicidal. Other risk factors include: prior suicide attempt; family history of mental disorder or substance abuse; family history of suicide; family violence, including physical or sexual abuse; firearms in the home; incarceration; and exposure to the suicidal behavior of others, including family members, peers, or even in the media.

Prevention

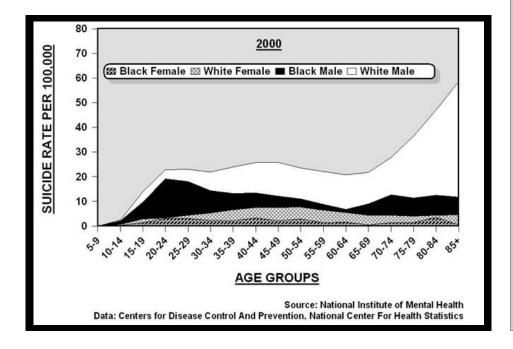
Preventive efforts to reduce suicide should be based on research that shows which risk and protective factors can be modified, as well as which groups of people are appropriate for the intervention. In addition, prevention programs must be carefully tested to determine if they are safe, truly effective, and worth the considerable cost and effort needed to implement and sustain them.

Many interventions designed to reduce suicidality also include the treatment of mental and substance abuse disorders. Because older adults, as well as women who die by suicide, are likely to have seen a primary care provider in the year prior to their suicide, improving the recognition and treatment of mental disorders and other suicide risk factors in primary care settings may be one avenue to prevent suicides among these groups. Improving outreach to men at risk for suicide is a major challenge in need of investigation.

Recently, the manufacturer of the medication clozapine received the first ever Food and Drug Administration indication for effectiveness in preventing suicide attempts among persons with schizophrenia. Additional promising pharmacologic and psychosocial treatments for suicidal individuals are currently being tested.

If someone is suicidal, he or she must not be left alone. Try to get the person to seek help immediately from his or her doctor or the nearest hospital emergency room, or call 911. It is also important to limit the person's access to firearms, medications, or other lethal methods for suicide.

from In Harms Way: Suicide in America, found at www.nimh.nih.gov





American Association of Suicidology

UNDERSTANDING AND HELPING THE SUICIDAL PERSON

Be Aware of the Warning Signs

There is no typical suicide victim. It happens to young and old, rich and poor. Fortunately there are some common warning signs which, when acted upon, can save lives. Here are some signs to look for:

A suicidal person might be suicidal if he or she:

- Talks about committing suicide
- Has trouble eating or sleeping
- Experiences drastic changes in behavior
- Withdraws from friends and/or social activities
- Loses interest in hobbies, work, school, etc.
- Prepares for death by making out a will and final arrangements
- Gives away prized possessions
- Has attempted suicide before
- Takes unnecessary risks
- Has had recent severe losses
- Is preoccupied with death and dying
- Loses interest in their personal appearance
- Increases their use of alcohol or drugs

What To Do

Here are some ways to be helpful to someone who is threatening suicide:

- Be direct. Talk openly and matter-of-factly about suicide.
- Be willing to listen. Allow expressions of feelings. Accept the
- Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of
- Get involved. Become available. Show interest and support.
- Don't dare him or her to do it.
- Don't act shocked. This will put distance between you.
- Don't be sworn to secrecy. Seek support.
- Offer hope that alternatives are available but do not offer glib reassurance.
- Take action. Remove means, such as guns or stockpiled pills.
- Get help from persons or agencies specializing in crisis intervention and suicide prevention.

Be Aware of Feelings

Many people at some time in their lives think about committing suicide. Most decide to live, because they eventually come to realize that the crisis is temporary and death is permanent. On other hand, people having a crisis sometimes perceive their dilemma as inescapable and feel an utter loss of control. These are some of the feelings and things they experience:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work
- Can't get out of depression Can't make the sadness go away
- Can't see a future without pain
- Can't see themselves as worthwhile
- Can't get someone's attention Can't seem to get control

If you experience these feelings, get help! If someone you know exhibits these symptoms, offer help and contact:

- A community mental health agency
- A private therapist or counselor
- A school counselor or psychologist
- A family physician
- A suicide prevention or crisis center

Depression and Suicide: An Eastern Perspective

Bv Nelson Adler The Guidance Center

ife is a precious gift. It often seems ordinary, for our world is populated with teeming life, yet it remains extraordinary. Some religious traditions (such as Tibetan Buddhism) adhere to the belief that a human life is an extremely rare and wonderful opportunity; an opportunity to grow and learn how to love oneself and others. Even with 8 billion humans populating the planet, many believe that each human life has the potential for amazing growth and accomplish-

Nevertheless, life sometimes appears to be drab, hopeless, and worthless to a large percentage of us every day. (According to some estimates, as many as one in twenty individuals suffers from depression for a significant amount of time in any given year.) No one ever said that the journey would be easy; every life contains some suffering, yet pain and suffering can be great teachers. If not for pain, many of us might fall prey to living dull and lazy lives, reveling in our so called accomplishments and achievements, thinking ourselves superior because we have achieved a little money, position, power, fame, sex. It is pain that leads us to ask "Why am I here? What is the purpose of my life?" Severe pain, unchecked, can lead to a downward spiral, where one's only thought is to escape. Yet, the same pain, if controlled, can be the greatest initiator

It is pain which often leads us to say, "Oh God, can you help me." How many of us say "Oh, God, thank you" for the "routine" miracles of our daily existence: the ability to breathe, move our bodies painlessly, see, hear, taste, touch, smell, think, communicate? Only when we lose one of these "givens" do we place true value upon them. A popular song of the Sixties (and again, today) has as it's main verse "Don't it always seem to go, you don't know what you've got till it's gone?" May we appreciate the many gifts we have while we have them, in all their abundance.

How is it that so many people suffer from depression? And how is it that so many people in the midst of depression act upon the self destructive and suicidal thoughts and feelings that they experience? How is it that so many individuals who suffer extreme depression are able to hang on? All thoughts and feelings are temporary,

see Eastern on page 57

The Guidance Center Offers Unique Vocational Training Opportunity

ARTWORKS is a socially-responsible retail store located in Mamaroneck, managed and staffed by adults with special needs, selling fine crafts and art by people with special needs.

ARTWORKS is currently seeking individuals with disabilities interested in obtaining vocational training in graphic arts, computerized design, and sales and management skills, as well as artists with special needs who wish to sell their art and crafts on consignment. Contact Cristina Boardman for details.

Sponsored by Verizon

Wednesdays, Fridays, Saturdays & Sundays: 12 PM-5 PM Thursdays: 2 PM-7 PM

628 Mamaroneck Ave. Mamaroneck, NY $(914) 632-7600 \times 220$ cboardman@tgcny.org



The Guidance Center is a health and human services organization that provides services to individuals with disabilities., Artworks is a Guidance Center vocational program,

Helping Families Heal From Suicide

By Dr. Brenda Shoshanna **Author and Lecturer**

hen there is a suicide, the victim is not only the one who has perished, but it's as if the entire family network has too. The individual and their family are inextricably interconnected, when we touch one part, the other feels it. The entire constellation must now be attended to. In order to do this effectively, it is crucial not only to deal with the enormous guilt each member is feeling but to truthfully understand the family dynamics that have been going on. Along with dealing with the suicide, other family issues often arise.

Within the family, there may now be a strong expectation that other family members will love and support each other in a way they may never have been able to before. In fact there is often an implicit demand by some that others come through for them, (terrible pressure can be placed on surviving children by parents in cases like these).

But a family member may not be able to come through for many reasons of their own. There may have been difficult or ambivalent relationships in the past. Now they are suddenly being called upon to give love that they just do not

However, if an individual does not



Dr. Brenda Shoshanna

comply, not only is there guilt within, but they may risk censure from the entire family as well. It is very important to bring this dynamic to light. Once it is looked at and discussed, a great deal of pressure may subside for all.

Undoing Guilt

sure of guilt is a crucial adjunct to health. Unfortunately, when a suicide takes place, guilt is a predominant reaction and initially, much of the interaction between family members may stem largely from this. There is not only survivor guilt, but the feeling that the person died because a family member did not love them enough, or give adequately in the past. Past difficulties in the relationship now surface to be resolved. This in itself may be quite hard

It is crucial to realize that guilt is a toxic force that erodes one's ability to work through issues. It also damages the quality of one's life. All interaction that arises from guilt inevitably goes the wrong way. It never produces the kind of satisfaction and comfort we are in real

By opening the way for family members to become aware of, accept and even express their feelings, a great deal of good can be done. The family members will no longer feel so alone. They will see that these feelings are natural and that they can be resolved. This, in itself, is very healing. They may grow to see that guilt is unnecessary, that they did all they could at the time.

There is a wonderful process for a family to use to help deal with guilt:

Process

- person who died that you feel you really should have done?
- Write it down. Make a list.
- Now, write down what you think the

- person would have liked you to do.
- What would you really have liked to do? What, realistically, could you have done?
- Notice the differences and similarities between the three lists.
- Now, go on. What has the person not yet done for you that you still wanted him to do?
- Write it down. Make a list.

Go over each list. Forgive yourself for what you could not yet do. Forgive the person who died for not fully giving

Now, see if it is possible for you to give what has been ungiven to someone who is still living. (This may be difficult in the beginning, but as time goes on it is a great source of healing. It allows our relationship with the deceased to be a source of growth for ourself and goodness for others.)

After this is done many have noticed that it is much easier to be at peace with

Expressing Resentment Carefully

While guilt may be common in some Anything that helps dissolve the pres- • What have you not yet done for the cases, fury and resentment rage on in others. A great deal of unresolved anger and animosity comes out in a family at a time like this.

see Helping Families on page 54

In The News...at the Office of Mental Health News

Verizon NY Adds Mental Health News To Employee Charitable Deductions List

Staff Writer Mental Health News

he holiday season is a time of giving, family, and community spirit. That spirit is evident as well at Verizon New York, the regions largest telecommunications corporation.

Several years ago, the Verizon Foundation launched "Verizon Volunteers," an employee volunteer program that provides matching funds for nonprofit agencies and encourages employees to spend more time and resources helping the agencies they care about the most. Verizon Volunteers gives employees the opportunity to donate funds to the nonprofit agencies of their choice by simply visiting the company's website and choosing from a list of worthy causes.

"Mental health organizations are a vital part of the fabric of our commu-

nity, and Mental Health News is providing an outstanding source of mental health education and hope to thousands of individuals and families through its award winning quarterly publication," said John F. Butler, Regional Manager for Community Affairs. "I wanted to have Mental Health News added to our web list of charitable organizations so that Verizon employees who support mental health causes can help this worthy organization."

According to Ira H. Minot, Mental Health News founder and publisher, "John Butler exemplifies the wonderful spirit and involvement that Verizon New York has with so many local and statewide organizations in our region. He has continually helped to inspire my efforts to bring Mental Health News to more and more people, and we truly appreciate this recognition as a newly listed organization in Verizon's employee giving program."

Board Chairman Announces Grant From the Bristol-Myers Squibb Company

Staff Writer Mental Health News

The Bristol-Myers Squibb Company of Princeton, New Jersey has just awarded a generous charitable education grant to Mental Health News. The announcement was made by Dr. Alan B. Siskind, Chairman of the Board of Directors of Mental Health News Education, Inc., the parent organization to the publication.

"This grant by the Bristol-Myers Squibb Company represents an outstanding effort by a leading manufacturer of psychopharmacological products to recognize the vital mental health education mission of our organization," stated Siskind.

The funds will help to expand the organization's ability to continue to build the organization's capacity to reach more individuals and families affected by mental illness.



Dr. Alan Siskind

Mental Health News 2003 Campaign Raises Vital Funds

Staff Writer Mental Health News

his year marked the first effort by Mental Health News to actively seek charitable gifts to help support its vital and ever growing mental health education mission. Several months ago letters went out requesting donations to the organization's Fall 2003 Annual Appeal. In addition during the past year, the organization received support from the Westchester and Orange County Department of Mental Health, a Management Assistance Program Grant by the United Way of New York City, a gift from the Rita J. and Stanley H. Kaplan Family Foundation in New York City, and the just announced grant from the Bristol-Myers Squibb Company.

"Our entire Board of Directors joins me in expressing our pride in this young organization's progress and the generous support that the community has given to help us continue to provide and expand our vital connection to people with mental illness," stated Janet Z. Segal, C.S.W., Vice-Chairman of the Board of Mental Health News Education, Inc.

In addition to the excitement generated by the outpouring of support during *Campaign 2003*, the New York State Psychiatric Association has just awarded its 2003 Warren Williams Award to Mental Health News Founder and Publisher, Ira H. Minot. Administered by



Janet Z. Segal, C.S.W.

the APA Area Councils, this award recognizes outstanding recent current activity and contributions in the field of psychiatry and mental health. A generous donation, funded by an annual grant from McNeil Pharmaceuticals accompanied the award which was presented to Minot by NYSPA President, Barry Perlman, M.D.

In an effort to give added recognition to supporters of the annual campaign for Mental Health News Education, Inc., we have compiled the following Honor Roll, and will continue to add names as they come in for this and future campaigns.

Mental Health News 2003 Honor Roll

Winifred Balboni

Helene Barsky

Barbara Bartell

John C. Becker

Joseph Bonaro

John Butler

Lois L. Cowan

C. Deborah Cross, MD

Joan Fabricant

Rena Finkelstein

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How The Body Speaks: Eating Problems, Self-Mutilation, Body Modifications

By Sharon Klayman Farber, Ph.D.

oday, increasingly more people are "coming out" about their self-mutilating behavior in much the same way that people began to "come out" about anorexia nervosa and bulimia in the 1970's. Cutting is only part of a spectrum of selfmutilating behavior. Other forms include burning, scratching, needlesticking, hair-pulling, and severe nail and cuticle biting and others. In addition, we are seeing a variety of body modifications, passive selfmutilation in which a person engages another to pierce, brand, cut, or tattoo his or her body. Selfmutilation is more of a problem than has been thought, and my own research has found that it often coexists with an eating disorder and serves many of the same psychological functions.

Those who harm themselves in these ways struggle with issues of body boundaries and ownership of the body, such as: How much space does my body take up? What is inside it? How does it work? How does it feel? Does it belong to me? Or does it belong to my mother, father, spouse or partner, to do with what they wish? There is a sense of being alienated from their own bodies, which makes it easy to treat their bodies as a thing, and thus abuse their bodies. And many people who do these things to themselves do it to claim ownership of their body, a common concern of adolescents and of those whose bodies had been abused. Not surprisingly, those with eating disorders and those who mutilate themselves or become "addicted" to the pain of piercing or tattooing have suffered considerable trauma in childhood, including separations and loss, family violence, physical or sexual abuse, coercive and intrusive medical and surgical procedures, and the more ordinary everyday trauma of being ignored, emotionally neglected, and robbed of a sense of self. Above all, they suffer from painful and traumatic attachments to the earliest and most important people in their lives, repeating the trauma in their self-harm.

Pain is a very subjective thing. When we have to tolerate the pain of a medical or dental procedure, we might find ourselves digging our nails into our hands, thus diverting ourselves from the pain of the procedure by inflicting another kind of pain on ourselves. It feels better to control one kind of pain than feel to feel controlled by another kind. So rather than feeling like the passive victim of others who preyed upon them or failed to protect them from harm, they inflict physical pain on themselves, a welcome diversion from emotional pain.

Traumatic events may involve real or perceived threats to ones life, evoking terror, helplessness, and the fear of annihilation. One is left feeling utterly powerless, without any sense of control, meaning, and human connection. Dr. Judith



Sharon Klayman Farber, PhD.

Herman, who has studied trauma has said, "The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma." But denied or dissociated experience has a power of its own. Like food that is stuck in the throat, the experience must be chewed, swallowed, digested and metabolized or the body will try to discharge it physically. The body will exercise madly, binge, purge, starve itself, cut or burn itself, or get itself tattooed or pierced repeatedly. When the voice is silenced by trauma, all that will emerge are such gestures. When the body attacks itself with a blade, this is a gesture that should make us wonder to whom the body is speaking and for whom the rage is meant. When the body weeps tears of blood, we

need to wonder what terrible sorrows cannot be spoken. When food that had tasted good suddenly feels like poison and has to be purged from the body, we should wonder what traumatic experiences exist that cannot be contained, metabolized, and integrated. One needs to decode the bodily narrative in order to understand the mysterious paradox and power of self-harm.

When the body speaks, the key questions to ask are: To whom is the body speaking? What is the body saying?

Trauma has been described as the experience of feeling ourselves to be utterly and completely alone. And it is the human attachment to another human being that saves us. Under the best of circumstances, such an attachment can occur in psychotherapy. There has been a problem, however, in self-harming people finding psychotherapy that is really helpful. First of all, many people who harm themselves have had painful, even traumatic experiences with mental health professionals, and are wary and distrustful. Second, it is no secret that most psychotherapists are equally wary and anxious around self-harming patients. Our training has not prepared us for patients who take potentially life-threatening risks. Patients who harm themselves may evoke intense feelings of anxiety and helplessness, at times even anger in therapists, who may insist that

see Body Speaks on page 30

Four Winds Hospital is the leading provider of Child and Adolescent Mental Health services in the Northeast. In addition to Child and Adolescent Services, Four Winds also provides comprehensive Inpatient and Outpatient mental health services for Adults, including psychiatric and dual diagnosis treatment.

Save the Date!



GRAND ROUNDS

Friday March 26, 2004 9:30 - 11:30 am

Childhood Bipolar Disorder



Joseph Biederman, M.D.

Chief, Clinical and Research Programs in Pediatric Psychopharmacology and Adult ADHD Massachusetts General Hospital, Professor of Psychiatry Harvard Medical School.

Dr. Biederman will review current developments in the diagnosis and treatment of pediatric Bipolar Disorder, particularly it's overlap with ADHD and conduct disorders.

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Body Speaks from page 29

the patient simply stop. Many therapists have little understanding of how precious these behaviors can be, and how trying to take them away only makes the patient feel that the therapist is trying to control him. Treatment may come to feel like a battle for control, and may ultimately fail.

If those of us in the mental health professions can overcome our fear of knowing about the darkest, most destructive part of the self that exists in some measure in all of us, we can come to understand more about the language of selfharm. One needs to know that despite the sometimes life-threatening nature of the self-harm, it may be more about living and surviving than about dying. That is, it may be the patient's best attempt to keep from hurtling into the abyss of suicide or psychosis. The physical pain they inflict upon themselves diverts them, at least momentarily, from their emotional pain, and so they crave it, developing an addictive-like relationship to self-harm.

Yet when a patient's behavior endangers his physical safety, this is an issue that must be addressed. Therapists need to help patients become responsible enough for their own physical safety so that the therapist need not fear for the patient's life. No therapist can be calm and thoughtful enough to treat a patient on an out-patient basis if he has real reason to worry that the patient might seriously hurt himself or die. Until the patient can assume greater responsibility for his physical safety, a more structured level of care such as inpatient or day hospital treatment may be necessary.

A sense of emotional safety in the relationship with the therapist is something that takes time to develop. If the patient can find a safe harbor with her therapist, this is an enormous achievement. At a time when so many people feel that there is nobody there for them, having a therapist who is reliably there and emotionally available can begin to turn the tide. To have nobody there means that they must rely on themselves, and so, not knowing what else to do, they turn in desperation to their own bodies. They may consider themselves sick, hopeless, and beyond help. If we consider that self-harm develops as a survival tool, then of course there is nothing sick about trying to survive severe psychic trauma. If the therapist can let the patient know from the outset that she must have good reasons for her behavior even if she cannot articulate what they are, that the therapist will work together with her to help

her to understand and articulate this, the conviction about this gives the patient a new and welcome idea about herself, one that emphasizes something good and healthy in her.

The aim of treatment is to help the patient develop the ability to define, tolerate, think about, and regulate her emotional states so that she does not have to rely upon hurting herself for self-regulation. The aim is to help the patient move from the language of the body to expressive spoken language. So instead of harming herself, she might become able to say, "I feel angry" or "guilty" or "sad" or "ashamed" or "frightened". Developing the ability to use words in this way is a tremendous achievement.

We all feel bad at times. It is part of the human condition. When one can speak to another about the chaos of emotions churning around inside, using words provides a sense of order to what had previously felt chaotic, and can transform depression and numbness into feeling and reflection. Having someone there to listen and try to understand makes it less lonely, and the feelings become more tolerable. And when this happens, there is less need to harm oneself.

Sharon Klayman Farber, PhD. is a Board Certified Diplomate in clinical social work in private practice of psychotherapy with children and adults in Hastings-on-Hudson, NY. She is the founder of Westchester Eating Disorders Consultation Services. She is on the faculty at the Cape Cod Institute. She is the author of When the Body Is the Target: Self-Harm, Pain, and Traumatic Attachments (Aronson 2000, 2002). Dr. Farber offers individual and group consultation and in-service training to mental health professionals who treat selfharming patients, and hopes to develop a supportive network of such therapists. She can be reached at (914) 478-1924. Website: www.Drsharonfarber.com.

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Oppositional Defiant Disorder

By Barbara Greenberg, Ph.D.

re you "afraid" to come home from work in the evening? Is your house filled with tension due to a constant struggle with everything having to do with your adolescent? Do you frequently feel incompetent in your own home?

You are certainly not alone. Every child tests the limits now and again, but it is the children with Oppositional Defiant Disorder (ODD) that push the limits to such an extent that nearly every conversation with him or her ends up being an exhausting power struggle or argument. As such, even the parent's relationship with one another often becomes stressed as each parent blames the other for the child's outrageous behavior. The transient oppositional behavior typically associated with early-childhood, adolescence, and other developmental stages needs to be ruled out before pursuing this diagnosis.

What to Look For

Symptoms of ODD usually become evident before the age of eight years old but not later than early adolescence. Associated fea-

tures of the disorder vary as a function of the individual's age and severity of symptoms. In the preschool years, warning signs include high reactivity, and difficulty being soothed. During the school years, children may experience low selfesteem, mood lability, low frustration tolerance, swearing and the precocious use of alcohol, tobacco, or illicit drugs. It is important to remember that an essential feature of ODD is a recurrent pattern of negativistic, defiant, disobedient and hostile behavior toward authority figures that persist for at least six months and is characterized by the frequent occurrence of at least four of the following behaviors which must occur more frequently than is typically observed in individuals of a comparable age:

- Loss of Temper
- Arguing with Adults
- Active defiance or refusal to comply with the request or rules of Adults
- Deliberately doing things that will annoy other people
- Blaming others for his or her own mistakes or misbehavior



Barbara Greenberg, Ph.D.

- Being touchy or easily annoyed by others
- Being angry and resentfully
- Being spiteful or vindictive

It is worthwhile mentioning that very often children and adolescents with ODD do not see themselves as persistently stubborn, resistant to direction, unwilling to do chores or tasks or especially argumentative. Rather, they justify their own behavior as a simple response to unreasonable demands placed upon them, or unreasonable circumstances into which they have been

thrown by their parents, teachers, or other authoritative adult figures who they feel do not understand them. These children often feel, but cannot articulate, that their parents are not attuned to their needs and feelings.

Oppositional symptoms often emerge in the home setting rather than at school, or during activities with peers. Many children who fit into the diagnostic criteria for ODD are often bright, well-liked, cooperative with teachers and coaches, and are polite to other adults. The incongruity of the behavior inside of the home easily reinforces that notion that the parents are to blame for their children's abrasive behavior towards them and others. There are times when the oppositional behavioral patterns can emerge at school and/or social settings, often suggesting to parents that teachers or others are to be blamed for the problems.

So, if Parents Aren't to Blame, What Causes ODD?

No one knows for sure. Most experts believe that a child's inherent personality and disposition contribute to the syndrome. Many times,

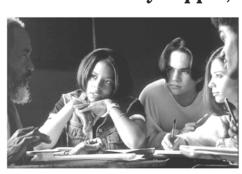
see ODD on page 32

Save the Dates...GRAND ROUNDS

Friday, April 16, 2004 9:30 - 11:00 am

Talking to Teens About Sex and Substance Abuse: An Open Dialogue

Cheryl Appel, M.D., FAAP



Rivertown Pre-Teen and Adolescent Medicine P.C. Tarrytown, NY Friday, June 4, 2004 9:30 – 11:00 am

Safety First, Interpretations Later: Treatment of the Self-Harming Patient

Sharon Klayman Farber, Ph.D.

Private Practice, Hastings-on-Hudson, New York. Author, "When the Body is the Target: Self-Harm, Pain, and Traumatic Attachments."

For Information Please Call 1-800-546-1754, ext. 2413

ODD from page 31

however, the symptoms become exacerbated in the home when the parents are not educated as to how to handle it. An informal survey of mental health professionals said that it is typical for parents with an ODD child to feel isolated and ineffective. Ross Greene, Ph.D., author of, "The Explosive Child" says, "You don't know anything about kids like this until you have one. Until people have walked in these parents' shoes, they have no idea."

Along with symptoms inherent to ODD, many times there are related problems such as hyperactivity, mood disorders, anxiety and conduct disturbances. It is sometimes more effective to treat a child or adolescent with ODD once some symptom relief is obtained through the use of medication for the problems related with this syndrome.

"These kids maintain an oppositional attitude even when it's clearly not in their best interest," says Ross Greene, "so we have to assume that they would be doing well if they could, but they lack the capacity for flexibility and frustration management that ordinary children develop."

Approach it from a Different Angle

In order to establish the diagnosis, parents should seek the help of a mental health care professional who is experienced in diagnosing children and adolescents. Individuals with ODD do not typically respond to the usual "rewards and punishments" systems established by parents and teachers. Rather, they need to be taught methods of coping with their own inability to handle frustration and impulsivity. Parents are best advised to remember that the child needs help dealing with difficult feelings. When your child is able to turn even the most simple conversation or event into a power struggle, you have to try to disengage until the situation calms down. Not easily done! In addition, carefully using humor to defuse an escalating situation is often very helpful. This often relives tension and gives the child permission to calm down. Seek assistance. Parents also need support and can benefit from learning some of the current, therapeutic techniques available to them and their child for coping with this disruptive disorder. Dr. Greene succinctly summarizes some thoughts and ideas regarding the inflexible-explosive child in the following paragraphs:

- Flexibility and frustration tolerance are critical developmental skills that some children fail to develop as they move beyond the terrible twos. Inadequate development of these skills can contribute to a variety of behaviors sudden outbursts, prolonged tantrums, and physical and verbal aggression, often in response to even the most benign of circumstances that frequently have a traumatic, adverse impact on these children's interactions and relationships with parents, teachers, siblings, and peers.
- How you interpret your child's inflexibleexplosive behavior and the language you

use to describe it will directly influence the strategies you use to help your child change this behavior.

• Putting your old interpretation on the shelf will also mean putting your old parenting practices on the shelf. In other words, helping your child to be more flexible usually means that you will have to be more flexible first. This isn't as unfair or unreasonable a statement as it may sound, for you've already experienced the futility of responding inflexibly to a child who is, by nature, inflexible. I've often used a simple equation to capture this phenomenon:

Inflexibility + Inflexibility = Meltdown

Essentially, the numerous variables that may be fueling your child's difficulties should be sorted out and evaluated by a mental health professional who will help you to develop a plan on how to proceed.

Dr. Greenberg is the Program Director of the "Lodge" Adolescent Unit at Four Winds Hospital. She can be reached by calling 914-763-8151 ext. 2482.

Resource: Greene, Ross W., Ph.D. "The Explosive Child" New York, Harper Collins.

SAVE THE DATE...

Friday, May 21, 2004 9:30 - 11:00 am





Music and Mood Disorders: Tchaikovsky

Richard Kogan, M.D.

Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital

Come hear Dr. Kogan discuss the impact of mood disorders on musical creativity.

For Information Please Call 1-800-546-1754, ext. 2413



The Mental Health News

New York City Section

What Does The President's Commission On Mental Health Have To Do With NYC?

By Lloyd Sederer, MD Executive Deputy Commissioner New York City Department of Health and Mental Hygiene

t's been 25 years since President Carter ordered the creation of the last Presidential Commission on Mental Health. First Lady Rosalyn Carter was at the helm and its report was front-page news in the New York Times. When Carter lost a second term, momentum was lost and a major piece of legislation subsequently repealed. A glorious beginning, yet a short lifespan. The President's priorities matter.

In 2002, President George Bush created the New Freedom Commission on Mental Health. In July, the Commission issued its final report. The story appeared on page 10 of the New York Times: a less than glorious beginning but with the prospect of reviving a national discussion on an issue too often neglected, and because of stigma, too often pushed to the side of the nation's health priorities.

There is much to applaud in the Commission's Report. It is optimistic that recovery is possible, as is a productive and proud life. The report encourages a person and family-centered approach to services and emphasizes the growing effectiveness of treatments and the steady advances in mental health sciences. Its honesty makes it credible: the national system is bluntly described as fragmented, disconnected and inadequate; "unmet needs and barriers" are legion.

This does not mean the report is complete. In some key ways, it does not go far enough. It does not identify, for example, how to get states and cities to achieve desired goals. Notably, it overlooks how the science of medical quality improvement can enhance the care of people with mental illness. Years ago,

when institutional care was the norm rather than the exception, people with mental illness were left to languish with little or no hope for their recovery. Today most people with mental illness live independently; many work and enjoy a good quality of life. We have also learned how to define, measure and improve the quality, safety and dignity of mental health services. The work of ensuring quality must be done locally, where services are delivered and improvements can be realized. Achieving effective and humane mental health services can become the defining operating directive of city and state agencies.

Issues of financing are also critical. Payment for mental health services must be fashioned to provide incentives for good care and we must stop supporting poor treatment. When money is spent more judiciously and efficiently more value derives, which helps in realizing what the Commission called "budget neutrality" (i.e., no additional money). In NYC we are committed to abolishing a decade-long state limit on how many Medicaid dollars can be spent for outpatient mental health care. This stems from the continuing refusal to see mental illness as a health condition worthy of the same treatment as other health disorders. People who need care for cancer, diabetes or any other health ailment are not similarly cut off from needed care. Until the cap is removed, mental health organizations can't afford to provide services because Medicaid won't reimburse them for doing so. The consequence is that many people go untreated, creating costs in shelters and hospitals. They also end up on public assistance rolls, and in correctional facilities, creating even greater governmental and societal costs.

Similarly, community-based group residences that provide care for 16 people or more also do not receive Medicaid reimbursement. This is because of a federal law that again does not consider



Lloyd Sederer, M.D.

the needs of people with mental illness. When the mental retardation and developmental disabilities community fought for an exemption from this exclusion years ago, legislators recognized that group homes were clinically necessary as well as economically far-sighted. Government invested public dollars to pay for them. Advocates for people with mental illness have not yet had similar success. This exclusion stands in the way of developing homes for people with mental illness, who need community living support but instead languish in scandalous adult homes, in shelters, or on our streets.

Changes in Medicaid rules, which now create discriminatory financial barriers to care such as these two mentioned, can and have been achieved, improving lives while not costing cities or states more money. The report stops short of urging these reforms.

We must also break down the walls

between those who provide care for mental and physical disorders. This should be done in at least two ways: in the care of people who suffer from a mental illness as well as an addiction or a developmental disability (such as mental retardation); and between general medical/primary care services and the mental health system. If one part of a person is treated while another is overlooked, treatment falls short and is excessively costly, individuals and families suffer, and social institutions including courts, jails and hospitals pay the price. While the Commission highlights these problems, it does not propose local solutions, where their reality is deeply felt and where the most hope lies for improving care. Cities and states can begin where the Commission stops short. We plan to do so.

In New York City, we will use the occasion of this report to support our efforts to improve the public mental health system. Our approach focuses foremost on quality mental health care: recipients of services should be able to access and receive the best care that exists. City government owes this degree of value purchasing to its residents. We are working to undo clinically, morally and economically foolish policies. As a merged health and mental health department we are breaking down the artificial barriers between medical and mental health services that prevent people from receiving the coordinated care that we know works best. And we plan to encourage the innovation that can make our system of mental health care even more safe and effective. If we do all of that, we will have met our obligation to the people of this City, and in so doing offer an example of how to improve care for people with mental illness to other communities across this country.

Mental Health News is Now Seeking Articles & Display Ads For These Exciting Upcoming Issues:

Spring 2004 Issue:

Eating Disorders: The Conflict Within

February 1st Deadline

Summer 2004 Issue:

Understanding and Treating Sleep Disorders

May 1st Deadline

Children Bereaved by the Suicide Death of a Loved-One

By: Cynthia R. Pfeffer, M.D., Director Childhood Bereavement Program New York-Presbyterian Hospital



Cynthia R. Pfeffer, M.D.

he ultimate outcome of people suffering from mood disorders, such as major depressive and bipolar disorders, and substance abuse, schizophrenia, and certain personality disorders is suicide. The suicide death of a loved-one begins a long process of searching for answers about why the suicide death occurred. People who lost a loved-one as a result of suicide are a cohort of individuals who often are isolated by their community and have perceptions of being stigmatized. Additionally, the trauma of witnessing the suicidal act or being exposed to the death scene produces intense distressing feelings of anxiety that is often associated with persistent and intrusive thoughts about what was observed. Being bereaved by suicide of a loved-one is a burdensome personal experience.

Children who lose a loved-one as a result of suicide suffer from similar concerns as adults. However, children often lack mature capacity to understand the nature of a suicide death. Furthermore, children's responses are shaped by their developmental level. Children's responses to the suicide of a loved-one are also dependent on their bereaved parents' coping styles.

Notably, having a parent who is bereaved by the suicide of a loved-one complicates the grieving of children. Importantly, a child who loses a loved-one as result of suicide usually loses their bereaved parent's usual degree of attention. The quality of the parent-child relationship is usually markedly altered by the combined parent and child processes of bereavement. Children bereaved by suicide of a loved-one also often lose the solace from peers and other adults, such as their peers' parents and teachers, because of the likelihood of secrecy and stigma often associated with suicide. Thus, the social support so essential for children's development is often weakened after children experience the suicide of a loved-one.

How do children react to the suicide of a loved-one? A prominent emotion is

overwhelming anxiety. It is associated with behaviors of clinging to their parents and fears that separation from the parent may cause something to happen to their parent. Children may exhibit frequent and increased irritability. They may not be able to sleep alone and want to be with their bereaved parent. They may report bad dreams or nightmares. They may show regressed behaviors such as bedwetting or talking like a younger child. Such bereaved children may have heightened problems concentrating and demonstrate fidgety behavior. They may complain of aches and pains, such as stomachaches, headaches, tiredness, and lack of energy. They may not wish to participate in activities that they usually enjoyed. They often are confused about what happened and find it difficult to speak with their grieving parents because they sense that their parents are having a difficult time enduring their own intense grief.

Sometimes children discover the deceased at the scene of the suicide death. This is one of the most profoundly traumatic experiences that children can experience. Such an occurrence usually causes acute stress reactions or posttraumatic stress disorder. Such reactions are manifest by behavioral and emotional problems. These include severe anxiety and efforts to avoid anything that reminds children about what was observed at the scene of the suicide death. Children are disturbed by intense intrusive thoughts about what occurred, feeling angry that the death occurred, feeling guilty that they may have caused the loved-one to die, and fears that other deaths of loved-ones may occur. Frequent behaviors displayed by such traumatized bereaved children are heightened impulsivity and hyper-reactivity, manifest by anxiety in response to sudden unexpected noises or events. Aggressive behavior and feelings of self-devaluation are expressed by such traumatically bereaved children. Some children who were exposed to a suicide death scene may have suicidal ideation as an effort to rid themselves of their painful emotions and problematic behaviors. These types of symptoms are expressions of acute stress disorder or posttraumatic stress disorder. They are often not recognized as manifestations of such psychiatric disorders and, as a result, interventions are often delayed or not provided to such children.

Most children who lose a loved-one as a result of suicide are not directly exposed to a suicide death scene. However, children may be exposed indirectly because they hear about the nature of the death from others. While it is important for children to have truthful information about how their loved-one died, it is essential that telling children about the suicide of a loved-one be carried out as a process and with sensitivity to children's developmental capacities. Parents may benefit from professional guidance in their efforts to inform their children about the suicide death of a loved-one.

The Role of Intervention for Children Bereaved by the Suicide of a Loved-One

Suicide of children's loved-ones is a

complex event for children and their families. Intervention in the form of guidance and counseling is often valuable for such families. Shortly after the death, families experience the shock and trauma of the death. Parents may be assisted to understand their children's needs regarding informing their children about the nature of the death, attending funerals, planning for daily routines for children and managing parents' own grief responses. Most important in the early period is to support the family in coping with the shock of their loss. Assisting parents to identify other supports for themselves and their children in the early period after the suicide death is an important aspect of intervention.

An important characteristic of intervention is creating an atmosphere for children and their parents to speak about their experience and responses to the loss. It is essential to determine if children, who are bereaved by the suicide death of a lovedone, suffer from psychiatric disorders or impairing symptoms that require special psychiatric intervention. Specifically, it is important to identify if acute stress disorder or posttraumatic stress disorder are present. Additionally, it is important to identify if bereaved children suffer from mood or anxiety disorders that also may require psychiatric intervention. Children's degree of social impairment resulting from the complex reactions to the suicide death are essential to identify so that intervention can be developed to decrease such social distress.

Evaluation of children's grief reactions is essential. This involves determining children's concepts of longing for the deceased, sadness and anxiety, guilt about causing the death, suicidal ideation related to wishes to join the deceased, and intrusive thoughts that may affect children's participation in usual activities and academics

Evaluation of children's understanding of the nature of the death and their degree of direct exposure to the death scene is essential. Intervention to decrease traumatic images of the death and to guide acquiring objective information about what is suicide is essential to preventing suicidal behavior of such grieving children.

Evaluation of grieving parents is essential with an aim of understanding their means of coping with their loss and need for knowledge about their children's bereavement. Evaluation of parental psychopathology resulting from their witnessing the suicide or exposure to the suicide scene is essential. Evaluation of parental social supports is necessary to help parents support their children. Parents have double tasks. They must attend to their own grieving. They must also attend to their children's grieving. How parents endure this requires evaluation.

Specific interventions are planned to be compatible with the issues identified during the evaluation of the above issues. For most children, the focus is on providing grief intervention. When severe symptoms associated with psychiatric disorders are identified, intervention should address reducing these symptoms. Similar concepts guiding intervention are applied for parents' concerns.

Interventions may be provided in individual formats or in group formats. Our experience in the Childhood Bereavement Program of Weill Medical College of Cornell University is that many children benefit from individual intervention because this provides maximum attention to children's needs to express their personal ideas and gain consistent support. Group intervention is provided to assist children to learn how other children cope with the death of a loved-one. The approach of the Childhood Bereavement Program at Weill Medical College of Cornell University is to work also with the parents of children bereaved by the suicide death of a loved-one. This approach addresses the specific needs of the parents to express their grief while gaining insights about their grieving children's needs.

As a compliment to the work of assisting parents to administer to the needs of their children, The Childhood Bereavement Program at Weill Medical College of Cornell University offers group meetings for parents who lost a child as a result of suicide. This group intervention provides such parents an avenue to focus on their specific bereavement needs. It enables them to explore their questions about what led to the death of their children, to explore their unique family features of bereavement, and to address their relationships with others in the community. The support from each member of the group strengthens parents' ability to cope with the trauma of their loss and to develop additional means of coping with their profoundly altered lives.

Need to Enlarge the Current Scope of Understanding

At present, there is sparse objective information about the long-term characteristics of children who suffered the loss of a loved-one resulting from suicide. How and whether such children's development is different from children who did not have this experience is important to determine. This can be accomplished through systematic follow-up of such bereaved children. The effects of the severe stress of such loss on children's development require discerning. The effects of parental coping with bereavement on the development of their grieving children are yet to be understood.

Efforts to prevent suicide can be derived by understanding the details of children's experiences subsequent to the suicide death of a loved-one. Bereavement intervention, with long-term follow-up of children bereaved by the suicide of a loved-one can support healthy development of such children while offering needed insights about how to interrupt the processes that may lead to suicidal behavior.

Dr. Pfeffer is a Professor of Psychiatry at Weill Medical College of Cornell University. You may contact Dr. Pfeffer by phone at 914-997-5849, or by Email, at cpfeffer@med.cornell.edu. Help is available at New York-Presbyterian Hospital in White Plains, and in Manhattan at York Avenue and East 68 Street.

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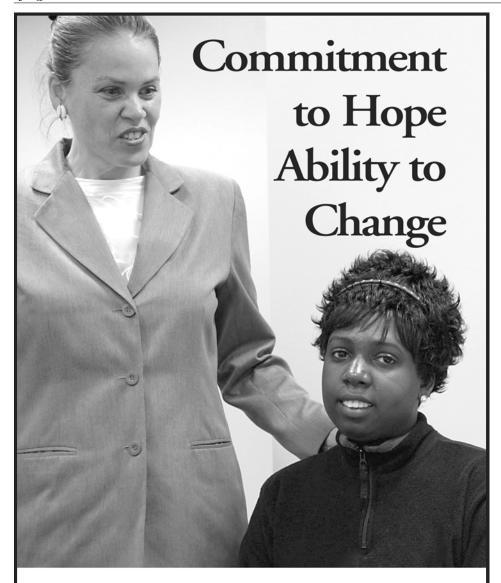
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Co-Occurring Disorders and Suicide Risk... A Daily Trauma

By Joyce Kevelson, Assistant Vice President, Behavioral Health Services, Dan Schlieben, MSW, and Donna Ray, CSW-R FEGS

uicide is the 11th most common cause of death in the United States and 13th worldwide. Research tells us that individuals with co-occurring mental illness and substance abuse disorders are clearly more at risk for suicide.

When Susan first arrived at FEGS/ Project COPE, a Dual Recovery program in Jamaica, NY, every day was a potential crisis: Susan (not her real name) who is diagnosed with Major Depressive Disorder and Cocaine Abuse, had overdosed on her meds after hoarding them for a three-month period. Through a formal risk assessment process, using the Addictions Severity Index (ASI), Susan was assessed at very high risk for suicide. Slowly but surely, Susan came to understand that her suicidal gestures were a maladaptive form of self-punishment, possibly a reaction to her guilt over abandoning her children. Susan began to verbalize her thoughts about her family, both at Project COPE and with her therapist at her outside clinic. "I am no longer using suicidal behavior as a way to express myself, but I still occasionally have those thoughts."

Susan and other clients with strongly expressed feelings about suicide, whether "gestures" or as "manipulation," are encouraged to participate in Dialectical Behavior Therapy (DBT) offered at Project COPE. "Getting into the habit of using DBT skills was hard at first but once I did they were helpful," she says. On other days, Susan attended Dual Recovery and Skill Building groups, all aimed at assisting her with developing insight as well as learning functional skills to use on days when she is not attending the program.

Susan participates in a unique program of dual recovery at Project COPE, which allows clients with severe emotional problems or mental illness to attend even while they may be struggling to recover from active drug use. Using a harm reduction approach with clients who are still struggling to achieve their goal of abstinence from drugs, has proven helpful. We have found that this strategy helps clients gradually achieve their goal.

"Building such a program for clients like Susan and others has been a real challenge," says Program Manager Donna Ray, who along with F.E.G.S Assistant Vice President Joyce Kevelson has championed Project COPE for the three years of its existence. The program occupies a bright, cheerful suite of rooms in a building on 161st Street in Jamaica, NY.

While Project COPE counts itself fortunate not to have had a suicide in the

program, staff are constantly vigilant of suicidal indicators and utilize accepted clinical tools to evaluate at-risk clients. The results of these evaluations may require further clinical assessment and often result in hospitalization. Statistically, nearly half of all psychiatrists and a third of all mental health professionals have experienced a suicide among clients. Unfortunately, ninety percent of people who commit suicide have a psychiatric disorder and of those, 60 percent have mood disorders - commonly major depression and bipolar disorder. Of particular concern are individuals like Susan, whose symptomology often comes in the form of suicidal gestures, perhaps as a way to regulate emotional distress. Additionally, clients who use drugs and alcohol have a heightened risk, as do those whose families have experienced suicide or suicide attempts.

"We are always very concerned about all of our clients," says Donna Ray, "and we work closely with other providers when we have a sense that a client is particularly vulnerable. We also know that programs like Project COPE can act as a safety net and teach important life skills and goal setting. Clients focus on positive outcomes within their reach, particularly in the areas of housing, learning, socializing, social supports and harm reduction. A sense of hope is often a deterrent to suicidal behavior."

Research suggests that suicidal clients must be evaluated for their ability to control impulses and take responsibility for their lives. Clients also need to be counseled to use "hot lines" and "buddies" and to talk about suicidal feelings whenever they are experienced. While such a revelation can be unsettling, even for those well trained in mental health, clients need to feel they will find support from all sources, including families and friends.

Dialectical Behavioral Therapy (DBT), developed by Dr. Marsha Linehan, of the University of Washington, is particularly useful for persons with personality disorders. Many therapists use this form of therapy to aid patients with new modes of thinking and to find better and more positive solutions. While such therapies are evidence-based, providing this modality of treatment for persons who are thought disordered is perhaps one of the most difficult challenges facing mental health and rehabilitation professionals, including the staff at Project COPE.

"Of all the challenges we face with dually diagnosed individuals who come through our doors, the risk of suicide is the most challenging. We train staff to be vigilant for clients' suicidal indications and to monitor them closely," says Donna Ray. "We are also dealing with social stigma which makes suicide and talk about suicide, especially among clients and even some staff, very

see Co-Occurring on page 55



The Coalition Report



Checking in on Our Democratic Presidential Candidates: Where do they Stand on Mental Health?

By Michael J. Polenberg **Coalition of Voluntary Mental Health Agencies**



Michael J. Polenberg

s the country moves closer and closer to the 2004 elections, it is worth spending a few minutes examining the positions on mental health policy articulated by the current crop of candidates seeking the Democratic nomination for President. While many of us have heard the candidates speak about the general need for "health care reform" in one manner or another, it is less apparent how each one would address the need for mental health care reform.

With this in mind, the Coalition of Voluntary Mental Health Agencies examined the positions of the nine current Democratic Presidential candidates in order to gain a deeper understanding of what they've accomplished in the field of mental health reform and where they would direct their resources should they win the Presidency.

We found that only a few of the candidates specifically address mental health issues on their campaign websites, which is unfortunate given the increased reliance by voters on the Internet for pertinent information. Inasmuch as they have not already done so, we believe it is extremely important that each of the candidates dedicate a portion of their campaign websites to mental health policy in order to allow consumers and their families, providers, advocates and other interested parties to more critically examine each candidate's commitment to these important issues.

The following summary of the candidate's positions is by no means exhaustive. Rather, it is intended to show our

readers how the candidates choose to publicly underscore their positions on mental health policy.

As the campaign progresses over the course of the year, and additional candidates enter or withdraw from the race, this publication will update its readers on the status of mental health issues in the

In the interests of impartiality, the candidates are listed in alphabetical or-

Carol Moseley Braun

www.carolforpresident.com

Ambassador Braun calls for a singlepayer health care plan that would allow every American to obtain insurance through the government. She also believes that doctors and nurses should be able to recommend a course of treatment regardless of what the insurance companies would pay for. Ambassador Braun does not make any specific reference to mental health policy on her website.

Wesley Clark

www.clarke04.com

Neither General Clark's campaign office nor his campaign website were able to provide any information on

where the General stands on mental health policy issues. Perhaps owing to the fact that he entered the race much later than his opponents, General Clark's campaign did not have any information to share with our readers by the time this issue went to press.

Howard Dean

www.deanforamerica.com

Governor Dean includes both "A Record of Accomplishment on Mental Health" and a "Mental Health Reform Agenda" on his campaign website.

Among Governor Dean's accomplishments during his tenure (1991-2003) was his enactment of insurance parity legislation in 1997. This legislation requires insurance companies in the State to provide equal benefits to persons suffering from psychiatric disabilities as they do for physical disabilities.

According to his campaign office, Governor Dean promises to enact parity legislation on a national level should he win election to the Presidency. In addition, he lists six other areas of mental health policy in which he would enact reform, including the use of treatment rather than

see Candidates on page 40



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Early Detection and Intervention Offers a Lifeline to Help Thwart Suicide

By Giselle Stolper, Executive Director Mental Health Association of New York City



Giselle Stolper

here are few words you can impart to grieving families that will alleviate their pain after the suicide of a loved one. The guilt that they could have done something to stop it, the rage and bewilderment at the senselessness of the act, and the sheer loss, cause enormous anguish to those left behind.

Survivors cannot comprehend how their relative or friend, no matter how troubled, evolved from feeling upset, to feeling desperate, to thinking about suicide, to actually committing suicide, all without others catching on and intervening before it was too late. They rehash conversations and interactions, scrambling for some clue of the suicide's state of mind, looking for the juncture at which someone could have stepped in and literally, stopped the madness.

There is no way to end suicide once and for all. Yet as mental health professionals, if we can identify individuals who are at risk of committing suicide, and if we can help them seek even a brief respite between when they begin thinking about killing themselves and when they might actually do it, we can help save lives.

At the Mental Health Association of New York City, we work toward early detection and appropriate intervention to help prevent suicide through our crisis and information and referral hotline, 1-800-LIFENET, and through our depression screening programs.

1-800-LIFENET Awareness that Leads to Intervention

One key to assisting in suicide prevention is to raise awareness of the symptoms

and behaviors to look out for among friends and relatives. Launched in 1996 in partnership with the Department of Health and Mental Hygiene, 1-800-LIFENET was created to assist persons seeking help for emotional, drug or alcohol problems by assessing their needs over the phone and linking them to the appropriate treatment and support services. Callers may be in crisis, or they may be experiencing ongoing problems in living. LifeNet is an information source for people who are concerned for themselves or their loved ones, and also gives people feeling hopeless and helpless a place to call, 24/7, before they turn to suicide.

1-800-LIFENET offers two advantages for the troubled caller. First, the hotline has authorized linkages with the City's crisis and emergency services, including Emergency Medical Services and the City's 25 psychiatric mobile outreach teams. When we receive an emergency call (defined by 911 and EMS as a situation in which someone can be a danger to him/herself or others within the next 24 hours) we can patch the call into 911 for immediate action.

Second, our hotline is staffed by mental health professionals, most with masters-level degrees, who can assess the caller's risk for causing harm and act quickly. In non-emergencies, LifeNet's referral specialists maintain the City's largest database of support and treatment resources, allowing them to find the most suitable options to meet the caller's individual needs. LifeNet also operates a hotline for Spanish speakers, 1-877-AYUDESE and Asian LifeNet, 1-877-990-8585. We use a translation service for other languages.

Most callers seek information and referral services to help them address a mental health issue and one-third of our calls are from case workers, friends or family who are calling on behalf of a client, friend or relative. Whether the call is from the individual or someone calling for another, LifeNet specialists probe to tease out atrisk behaviors and thoughts, all of which can indicate a suicide in the making. For instance, we determine whether the individual potentially at risk has a history of self-injury, whether he or she has access to a means for committing suicide (a gun, a bottle of pills, etc.), how frequently he or she has talked or thought about suicide, and how concrete plans may be (if the person has considered a date or a method, for example). Just as important, our professionals ask if the individual had someone close to him or her who actually committed suicide, because it sets a precedent that can seem like a go-ahead to someone struggling with suicidal thoughts.

LifeNet conducts continual outreach to circulate the hotline number and ensure people struggling with emotional difficulty have the number on hand when times get tough. In addition, LifeNet and the

DOHMH utilize active public education campaigns, targeted at specific audiences – seniors and adolescents, for instance – to increase awareness of mental illness and remind people there are life-affirming alternatives when they begin to believe suicide is a viable option. In the past seven years LifeNet and DOHMH have conducted nearly a dozen campaigns throughout the City. Examples of posters from these campaigns are featured on the next page.

Several measurements indicate the hotline is doing its job of building awareness and providing a resource for those at risk and those who want to help another. LifeNet call volume grew from just under 1,000 calls per month in 1996 to 3,000 calls per month in 2001. Since the events of September 11th, call volume has doubled to average 6,000 calls per month.

Beyond sheer volume, the content of calls has changed. At the time of LifeNet's founding in 1996, one in 35 calls to the 1-800-LIFENET hotline constituted an emergency. Today, approximately one in 120 callers reports such an emergency. That favorable change in ratio indicates callers utilize the hotline more for information and referral – before their problem reaches crisis stages – using their awareness of LifeNet to reach out when the issue at hand is challenging but not life-threatening. This is a trend we plan to continue.

Early Detection for Suicide Prevention

Suicide rates among people with emotional disorders is disproportionately high, especially for depression, bipolar disorder, and anxiety-related disorders. This is where early detection can prove critical in suicide prevention. The MHA of NYC is one of the area's leaders in providing mental health screenings through our Community Outreach and Public Education (COPE) campaign.

In the last issue of *Mental Health News* we described COPE's depression screening program for the junior high and high school level, to identify students most at risk for depression and to help them access treatment quickly. The National Institute of Mental Health (NIMH) cites that among teens and college-age students, suicide is the third most common cause of death after accidents and homicide.

COPE also conducts active mental health screening, primarily for depression, among senior citizens. It may be surprising, but seniors comprise the highest atrisk population in the United States. NIMH notes that Americans over 65 make up 13 percent of the population, yet in 2000, accounted for 18 percent of the nearly 30,000 suicides committed that year. White males aged 85 and over comprised the largest group within that category.

Our screenings for depression take place at senior centers and schools throughout the city, including in Latino and Asian communities. The screening day includes offering discussion and a brief questionnaire that the participants complete and then review in one-on-one meetings.

During a presentation, COPE staff discuss symptoms of depression so the participants can identify signs in themselves and among their friends, and they circulate the LifeNet phone number — though seniors and youth are less likely to make a phone call in this instance. However, faceto-face, seniors are eager to discuss their issues and feelings, quite a departure from the stoicism or skepticism many would expect to find within the age group. For youth, MHA of NYC's COPE staff works closely with school faculty and parents to ensure that children and teenagers identified as "at risk" get the help they need.

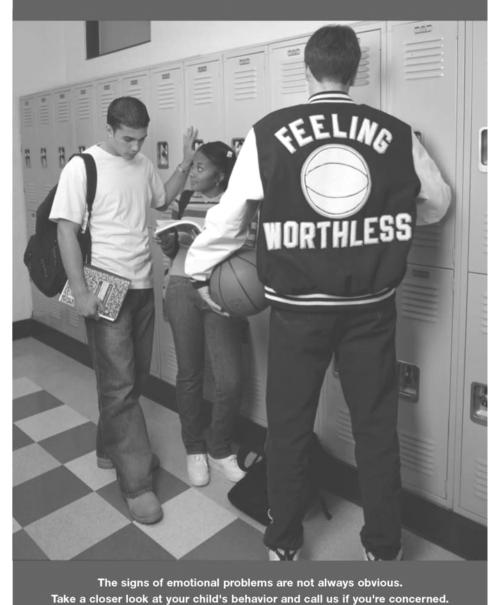
COPE staff also offers training programs on grief and loss and stress management. We have worked with the Department for the Aging's Partner to Partner program, a group of peer educators. COPE professionals trained these advocates to identify the symptoms of depression among their peers. We have also conducted screenings with the Department of Aging's grandparent resource centers and support groups for grandparents raising grandchildren.

For COPE staff, informing seniors, youth, family members, school faculty and caregivers about 1-800-LIFENET is central to their overall outreach efforts, so persons can know that there is a place to access help at any time, on any day, whenever it is needed.

We cannot overemphasize the importance of the community in our efforts to prevent suicide. One of our primary missions is to help friends, family members and other professionals to better recognize mental health problems among the persons they know and care for, so persons feeling alone with their suffering can be directed to receive the help they need. The 1-800-LIFENET hotline offers a caring, professional ear to anyone who may want to reach out but doesn't know whom to call, and depression screening can help identify those who are at risk. If you are interested in hosting a depression screening program for your group or organization please contact Dr. Rachelle Kammer, Director of the COPE campaign, at the Mental Health Association of New York City at 212-614-6300.

Dr. John Draper, Director of Public Education and the LifeNet Multicultural Hotline and Dr. Rachelle Kammer contributed to this article.

If only the signs were this easy to read.



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Joyce Wale, Assistant Vice President - Behavioral Health New York City Health & Hospitals Corporation

> Peter Yee, Assistant Executive Director Hamilton - Madison House

> > committee in formation

Candidates from page 37

incarceration for mentally ill offenders, funding peer support and counseling, and adequately funding employment programs for mentally ill Americans to allow them to shift from public to private health insurance.

Governor Dean would also seek to invest in programs that integrate mental health care with substance abuse treatment, specialized housing, and other social services; fund specialized programs that identify and assist children with psychiatric disabilities; and promote community-based care as a more cost-effective manner in which to provide treatment.

John Edwards www.johnedwards2004.com

Senator Edwards campaign platform includes a plan to increase insurance coverage, reduce disparities in health care, and add 100,000 nurses over five years. His plan would offer health insurance to every child in America, and millions of adults. While in the Senate, Mr. Edwards introduced legislation that would reduce the cost of medication by \$60 million over 10 years. Mr. Edwards also sought to provide critical mental health and substance abuse services to women who are victims of domestic violence or sexual assault (Women in *Trauma Act, 2002*). More recently, Senator Edwards announced a \$20 million initiative that would help disabled Americans find work ("Breaking Down Barriers" Initiative).

Senator Edward's campaign also outlines his plan for a Clinic Preservation and Improvement Program (CPIP), which would greatly increase funding for public health clinics. In addition to extending hours and re-locating clinics to more accessible areas, the CPIP would promote preventive and educational measures that target mental illness and substance abuse, among other ill-

Richard Gephardt

www.dickgephardt2004.com

Representative Gephardt's campaign includes a plan to offer health coverage to 97% of uninsured Americans. One of Representative Gephardt's accomplishments during his tenure in Congress has been the "Ticket to Work and Work Incentives Improvement Act" (1999), which allows Americans with disabilities to qualify for Medicaid and Medicare without having to give up their employment. Representative Gephardt was also a co-sponsor of the Americans with Disabilities Act of 1990.

John Kerry www.johnkerry.com

Senator Kerry includes a Statement on Mental Health Policy on his campaign website, and his campaign office provided a record of accomplishment in this area during his tenure in the U.S.

Senator Kerry is a member of Congress' Health Care Subcommittee, and has introduced several pieces of legislation to provide assistance to Americans living with psychiatric disabilities. Senator Kerry co-authored the "Medicare Mental Illness Nondiscrimination Act" and the "Medicare Mental Health Co-payment Equity Act", both of which seek to lower the cost for mental health treatment for Medicare recipients.

Senator Kerry's Statement on Mental Health Policy calls for parity in both public and private insurance programs. He would allocate resources to community-based mental health care to target underserved populations such as women and minorities, and would work towards de-stigmatizing mental illness in order to encourage more Americans to seek treatment and counseling.

Dennis Kucinich www.kucinich.us

Representative Kucinich's campaign emphasizes his support for disability rights, including his pledge to fund community-based care and his support for mental health parity in insurance coverage. A campaign spokesman noted the candidate's co-sponsorship of H.R. 676, which includes mandatory parity in health care coverage. Representative Kucinich would also nominate judges who expressed their support for the Americans with Disabilities Act to ensure that all Americans are treated fairly. The candidate would also look for a Congress that would enact meaningful health care reform.

Joseph Lieberman www.joe2004.com

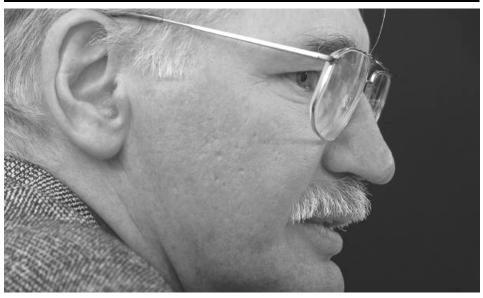
Senator Lieberman's campaign notes the economic impact of untreated mental illness on the business community in terms of lost productivity, and that reductions in care to mental health programs inevitably shift the cost to prisons and jails. Senator Lieberman received an "A" from the National Alliance for the Mentally III (NAMI) in 1998, and in 2000 was named one of NAMI's Legislators of the Year for his efforts to improve conditions in hospitals and mental health institutions, particularly regarding the use of restraints.

If elected President, Senator Lieberman would pass legislation that would require mental health and substance abuse parity for public and employerbased insurance plans in order to more effectively treat Americans suffering from these afflictions. Senator Lieberman will also work towards ending racial disparities in health care.

Al Sharpton www.al2004.org

Reverend Sharpton's campaign advocates amending the Constitution to add the right to health care for all Americans. Unfortunately, his campaign did not provide more specific details, particularly concerning mental health policy, by the time this issue went to press.

Suicide and Older White Men



By Benjamin R. Sher, MA, CSW **Director of Training** and Staff Development **Institute for Community Living, Inc.**

uicide ranks between the 8th and 11th leading cause of death in the United States. Three factors have been identified for risk of suicide; race, gender, and age. Statistics indicate that while women attempt suicide more often than men, men are four times as likely to complete suicide. In Healthy People 2000, the rate of suicide for white males aged 65 is noted as 34.1 suicides/100,000 people. For white men 85 and older, this rate increases to 100+ suicides/100,000 people. Suicide and older white men in America is a national health concern.

Risk Factors

Individuals experiencing clinical depression are at risk for suicide, as well as other mood disorders such as dysthimia and manic-depression. Often, these disorders go undiagnosed in older white men. Alcohol or substance use may mask the symptoms of depression, or the problems of depression are linked to a health concern that is the primary focus of the physician treating older white men. Treatment of a chronic medical condition such as cardiac problems, diabetes, hypertension, or Alzheimer's may promote depression. Many of the medications prescribed for treatment may cause depression as a side effect.

Social factors may also promote risk. The developmental milestone for older persons is an ability to focus on generativity or end up in despair. Older people who feel a sense of accomplishment in their life, have connections to people, are active, and experience pride in their successes are less at risk for depression than older persons who feel their lives have served no purpose. This is also the time of loss in life. Older persons who lose a spouse or loved one and cannot adequately grieve may believe living serves no purpose and a wish to be with one who died. This appears particularly true for older white men, who may not have been well socialized to express their loss and grief.

Even economics play a part in suicide risk. It has been found that older white male professionals are at risk for suicide. Though not fully clear, the reasons for this risk may be linked to concern for loss of productivity as one gets older or worry that one cannot "measure up" to one's former self. Some of America's highest paying professions (e.g. medicine) have a higher than average statistic of suicide.

Interventions

Assessment for clinical depression in older white men is the primary means to promote suicide prevention. Studies have shown that numerous men had contact with their primary care physician in the months before ending their life. A full mental status completed by a physician may help to reduce risk.

Knowing the warning signs and risk factors will also help. An older white male who loses his wife of many years should be supported and connected to as many social outlets as possible. Increased alcohol use or abuse of prescribed medication may be a warning sign. Thoughts about taking one's life, or open statements about "ending it all" should be taken seriously, and asking a person if they have plans to kill themselves is critical. There is often a fear that openly asking about suicide will promote it - this is a myth. More often than not, people who attempt suicide have been thinking about it long before someone asks them about it. Other risk factors include isolation, marked changes in behavior, giving away lifelong possessions, or purchasing firearms or weapons.

Suicide and older white men is a national health problem. Given the vulnerability of this population for completed suicides, it is crucial that medical and mental health professionals collaborate to determine and assess risk. Early intervention and proactive measures are certainly ways to address this problem. The earlier that depression is identified in older white men, the better it can be treated. As in all other mental health concerns, treatment for suicide prevention works.

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AFSP College Film Completed

Pilot-testing to begin in Early 2004

The American Foundation for Suicide Prevention

he Foundation's short-length film about depression and suicide for the college-age audience has been completed and will be pilot-tested during the upcoming spring semester before being distributed to colleges and universities nationwide.

The primary goal of the film, titled *The Truth About Suicide: Real Stories of Depression in College*, is to present a realistic and recognizable picture of depression in college-age youth while encouraging those suffering from depression and other psychiatric disorders to seek treatment or to help a friend seek treatment.

Filming took place at colleges and universities in the Atlanta, Boston and Portland, Ore. areas, with additional footage shot in New York City. Ant Hill Marketing, who is producing the film, edited over 40 hours of raw interview footage to create the 25-minute film.

The AFSP college film is part of a growing initiative to help the 18-to-24 demographic to recognize depression as a serious mental illness; an illness that if left untreated, can lead to suicide.

Recent studies have shown that one in 10 U.S. college students have seriously considered taking their own life.

The film's priority messages:

- Depression is a common problem that interferes with students' ability both to enjoy college and be productive in their work. Depression can or will affect you or someone you know.
- Depression is a real illness and is not a sign of some character weakness.
- Depression is especially dangerous when accompanied by: severe insomnia, anxiety, hopelessness, desperation, feelings of being out of control, and excessive use of drugs and alcohol.
- Depression can lead to suicide.
- Warning signs of suicide include changes in mood and behavior which can be sudden or gradual.
- Treatment works and it's smart to seek treatment before things get out of hand.
- Identify resources and available treatment options.
- If students are depressed they should seek professional help; if their friends are depressed they should support them in seeking help.

For more information about the AFSP college film, call 1-888-333-AFSP, or visit www.afsp.org.

AAS from page 24

What can we all do to help?

- We can advocate for better funding; we can donate monies ourselves to further suicide prevention efforts, education and training, and research studies.
- We can become actively involved in state and community coalitions formed and forming to promote suicide prevention efforts.
- We can better observe our children, our elders, our peers, and our loved ones; and when we notice anything of concern, we can ask directly whether suicide thoughts are present. No one kills themselves because they were asked about suicide; people die because no one cared to ask.
- We can do everything possible to help those we care about to receive competently delivered treatment and to comply with caregivers' recommendations.
- We can safely store our firearms and, even better, remove their immediate access to family members at-risk.

- We can refuse to any longer tolerate a society that does not care enough to do all possible to help people lead more well-functioning lives.
- We can get involved and join with others who are actively working to prevent unnecessary deaths by sui-

For more information visit the AAS website: www.suicidology.org.

Sources:

- American Association of Suicidology www.suicidology.org
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Mental Health News

Fairfield County Section

Greenwich Danbury BRIDGEPORT Stamford Ridgefield Norwalk

Courage To Speak: Addressing Drug Prevention

Staff Writer Mental Health News

at Vigilio's 7th grade health class at the Ponus Ridge Middle School in Norwalk, CT, was in the middle of the fourth activity in the new Courage To Speak Drug Prevention Curriculum for Middle Schools. Piloted earlier this year, the program is now being implemented in six Norwalk middle school health programs and another in Bridgeport. The students had just completed presenting their first drafts of posters containing their own drug prevention messages to the rest of the class.

The Curriculum was developed by The Courage To Speak Foundation, a Connecticut nonprofit founded by Virginia "Ginger" Katz and her husband Larry Katz. Its mission is to save lives by inspiring youth to be drug free through fostering open education and discussion. The Katzes are the mother and stepfather of a 20-year-old son, Ian Eaccarino, who tragically succumbed to a heroin overdose in late 1996. Several months later, the Katzes created The



Ginger Katz

Courage To Speak whose mission recognizes the insidious role of silence and denial in drug and alcohol addiction.

"I could not sleep the night before Ian's burial for thinking about what I would say to the hundreds of people who would be at the service." Like many whose loved ones are victims of substance abuse, Ms. Katz felt both internal and external pressure to keep the cause

of her son's death a secret. "I woke Larry and told him that there was no way I could get through the funeral. Knowing the truth and not wanting to reveal it was holding me back. Larry held me and as we talked, a new idea came to me, more of a revelation really than an idea. I said to him, 'I want to speak out. We can prevent other families from suffering what we have suffered by telling them what happened to Ian—if we tell them the truth.' 'Yes,' he said. 'That's what we'll do.' "

The Katzes then embarked on a crash course to educate themselves about drug use and prevention and started their organization in 1997. Since then, they have given nearly 400 presentations reaching over 100,000 children and parents in Connecticut, New York (including Westchester), New Hampshire, Maine, New Jersey, Pennsylvania, Massachusetts, Nevada, Indiana, and California. She has been invited to speak at state, regional, and national conferences on prevention and The Courage To Speak has been highlighted on the websites of major prevention organizations like the Partnership for a Drug Free America and the Center for Substance Abuse Prevention (CSAP) and the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. In recognition of her organization's efforts, Connecticut's Governor John Rowland has designated October 3 as "Courage To Speak Day."

Recent studies indicate that most school-based prevention programs fail because of the lack of ongoing followup. Ms. Katz said, "My experience tells me that there is a second reason for this failure. Providing information about drug use and its consequences is just not enough. We have to prepare the ground first by reaching kids directly and personally so we can earn their trust and commitment." She accomplishes this by combining her intensely personal story of a family shattered by drugs with the latest information and statistics on substance abuse and prevention. Ms. Katz speaks with a quiet intensity and rigorous emotional integrity that encourages her young listeners to trust her and the advice, information, and statistics that she and Mr. Katz offer.

"Hundreds of kids speak to me after our presentations," said Ms. Katz, "or send us e-mails expressing their compassion and their intention to resist using drugs and alcohol. But that's not enough. Then we-schools, families and the community—have to give them

the programs and support they need throughout their school years to maintain their commitment to reject drugs."

To provide this ongoing support and mentoring The Courage To Speak recently developed its "Drug Prevention Curriculum for Middle Schools" with the invaluable help of local educators and social service providers in Norwalk, and the support of community philanthropic organizations like the Fairfield County Community Foundation and Norwalk and Wilton chapter of the United Way.

Successfully piloted last January, the 18-hour program begins with Ms. Katz' presentation and is followed by eleven teacher-led in-class activities and a special presentation designed for parents. If students reveal a need for professional help or teachers detect it, their principals refer them to local service providers with whom The Courage To Speak has close working relationships who follow up and provide the students and their families with appropriate support.

At the core of this program is the personal story of an intelligent and popular boy who seemed to have everything yet still made the wrong choices. The students' compassion for him and his family are a constant motivating force for their committed participation.

One indication of the effectiveness of the program is that after some very effective student letters to the editor appeared in Norwalk newspapers saying that the Courage To Speak curriculum should be in every school, educators and parents asked Ms. Katz to adapt it for high schools and elementary schools. This process will begin in November.

"To say it in one sentence," says Ms. Katz, "we are reaching into our kids' hearts with our story and then feeding their minds—with the help of the Curriculum and their teachers—with the information and tools they need to change their lives and help their communities fight drugs."

Back in the classroom, Vigilio asked his seventh graders, "How long do you think it took you to present your prevention message?" They agreed it took about a minute and half. His next question, "Do you think if Ian had been able to do that he would have started using drugs?" elicited a sober round of no's from his class whose imaginative and well-articulated posters will be displayed for the entire school and their parents to learn from.

To find out more about The Courage To Speak and its programs log on to www.couragetospeak.org.

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American Association of Suicidology

YOUTH SUICIDE FACT SHEET

- Suicide ranks as the third leading cause of death for young people (ages 15-19 and 20-29); only accidents and homicides occur more frequently.
- Each year, there are approximately 12 suicides for every 100,000 adolescents.
- Approximately 12 young people between the ages of 15-24 die every day by suicide.
- Within every 2 hours and 2.5 minutes, a person under the age of 25 completes suicide.
- In 2000, 29,350 people completed suicide. 13.6% of all suicides were committed by persons under the age of 25.
- Whereas suicides account for 1.2% of all deaths in the U.S. annually, they comprise 12.8% of all deaths among 15-24 year olds.
- Suicide rates, for 15-24 year olds, are 300% higher than those of the 1950's, and remained largely stable at these higher levels between the late 1970's and the mid 1990's.
- Suicide rates for those 15-19 years old increased 11% between 1980 and 1997. Suicide rates for those between the ages of 10-14, however, increased 99% between 1980 and 1997. Both age groups have shown small declines in rates in the past two years.
- Firearms remain the most commonly used suicide method among youth, regardless of race or gender, nearly accounting for almost three of five completed suicides.
- Research has shown that the access to and the availability of firearms is a significant factor in the increase of youth suicide.
- The male to female ratio (in 2000) of completed suicides was 3.7: 1 among 10-14 year olds, and 5: 1 among 15-19 year olds, and 6.2: 1 among 20-24 year olds.
- Black male youth (ages 10-14) have shown the largest increase in suicide rates since 1980 compared to other youth groups by sex and ethnicity, increasing 180%. Among 15-19 year old black males, rates (since 1980) have increased 80% (2000 data).
- Research has shown that most adolescent suicides occur in the afternoon or early evening and in the teen's home.
- Although rates vary somewhat by geographic location, within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- Nationwide, nearly one in five high school students have stated on self-report surveys that they have seriously considered attempting suicide during the preceding 12 months.
- A prior suicide attempt is an important risk factor for an eventual completion.
- The typical profile of an adolescent nonfatal suicide attempter is a female who ingests pills; while the profile of the typical completer suicide is a male who dies from a gunshot wound.
- Not all adolescent attempters may admit their intent. Therefore, any
 deliberate self-harming behaviors should be considered serious and in
 need of further evaluation.
- Most adolescent suicide attempts are precipitated by interpersonal conflicts.
 The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- Repeat attempters (those making more than one nonlethal attempt) use their behavior as a means of coping with stress and tend to exhibit more chronic symptomology, poorer coping histories, and a higher presence of suicidal and substance abusive behaviors in their family histories.
- Many teenagers may display one or more of the problems or "signs" detailed below. The following list describes some potential factors of risk for suicide among youth. If observed, a professional evaluation is strongly recommended:
 - Presence of a psychiatric disorder (e.g., depression, drug or alcohol, behavior disorders, conduct disorder [e.g., runs away or has been incarcerated]).
 - The expression/communication of thoughts of suicide, death, dying or the afterlife (in a context of sadness, boredom, or negative feelings).
 - 3. Impulsive and aggressive behavior; frequent expressions of rage.
 - 4. Previous exposure to other's suicidiality.
 - Recent severe stressor (e.g., difficulties in dealing with sexual orientation; unplanned pregnancy or other significant real or impending loss).
 - 6. Family loss of instability; significant family conflict.

Hall-Brooke President Urges Focus on Children's Mental Health

By Stephen P. Fahey, President and Chief Executive Officer Hall-Brooke Behavioral Health Services



Stephen P. Fahey

o one can disagree that our society's future is in the hands of our children. That knowledge effects many political stances, from President Bush's education support slogan, "Let no child be left behind," to Senator Hillary Clinton's child nurturing philosophies in her book, "It Takes a Village to Raise a Child."

In our area of Connecticut, the predominant stories in local newspapers seem to indicate a powerful interest in the well being of our youngsters. Debates continue over partial versus full day pre-school, over the educational impact of alleged "sleep deprivation," caused by opening bells some parents deem too early. We read of concern over school lunch quality and playground size. Many regional communities are accepting sizable tax increases for the sake for new school buildings, in the belief that spacious, well-equipped physical plants are necessary for effective learning environments.

Meanwhile, on the state level, failures of an over-burdened, underfinanced Department of Children and Families (DCF), have led to the State's accession of a shared, but legally dominant, role of the Federal Government in the agency. Other states, also, face crises in management of the agencies serving their children and families. We've all read horror stories in the national press of children lost in various state care systems, and of abuse in foster parent settings. This does not mean that

there are no success stories, or that some foster parent's aren't loving and caring people.

So the record of protecting and preparing our children to run our nation is very mixed. There are many successes: wonderful stories of kids who win science competitions, youthful musical wonders, inspirational student leaders, and high school athletes who are role models. But, there are too many dark stories. And continually being ignored is the 'elephant in the room': the importance of mental and behavioral health of children and adolescents.

We read that a child who takes his own life, "was a model student." We hear youthful shooters described as "loners, subjects of hazing." In both cases, parents, teachers, friends and others in a child's circle of life, were blind to, or ignored symptoms of mental illness and the lack of behavioral health. And there were symptoms. In some cases, adults have allowed toxic environments to develop and prevail, where hazing is considered "part of growing up," and is dismissed as a "kids will be kids" fact of life. We've averted our eves to conditions which can have serious and negative effects on behavioral development.

Many children who need psychiatric or behavioral help don't get it because of the stigma they and/or their parents feel is attached to treatment. Others go untreated because the adults in their life simply fail to recognize certain behaviors as symptoms. A child seen as "bad," troublesome, or hard to manage, may really be a very sick child. Often, that child can be successfully treated. A moody child, may be simply that, or may be in a state of clinical depression. Help is available, not just for treatment, but for the determination of whether, or not, treatment is needed.

Hall-Brooke has a special concern for children and adolescents and provides the region's most comprehensive behavioral care for them. Hall-Brooke's mission includes serving as a regional resource for information on diagnosis and treatment of mental illness and/or substance abuse. In line with this, we're holding informational events which focus on the mental health of children and adolescents.

Good mental health effects every part of a child's life: performance in school, relationships with peers, family dynamics, and, his or her future.

We must all work to destignatize mental illness and to provide access for all children to mental health services, when these are needed. Then our children will truly be prepared to take society's future into their hands.



In June 2001, Hall-Brooke Behavioral Health Services opened a new 58,000 square foot, residential style treatment center on its beautiful 24-acre main campus in Connecticut

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Department of Psychiatry

Suicide Services in Connecticut

By Anthony LaBruzza, MD, Chief of Medicine and Jason Spann, Outreach Clinician, Greater Bridgeport Community Mental Health Center, Southwest Connecticut Mental Health System. Connecticut Department of Mental Health and Addiction Services

ersons who are dealing with suicidal thoughts or gestures often seek assistance from the mental health community. The level of assistance depends on the severity of the suicidal action or intent. The first priority is to prevent death or disability from a suicide attempt. The second step is to treat the underlying condition that is prompting the suicidal thinking.

In cases where suicide appears imminent or a person has just made a suicide attempt, it is best to call 911 and have the person taken to the emergency department of a local hospital. There trained professionals can assess the seriousness of the suicidal threat or action and can advise a further course of action.

In cases where a person is troubled by suicidal thoughts but has no imminent plan or intent, it is advisable for that person to discuss such thoughts with a mental health provider. Private insurers provide such lists to their subscribers. Department of Mental Health and Addiction Services (DMHAS) has a number of crisis services throughout the state, and non-DMHAS clinics also may provide such services. Family members can also call if they have questions or concerns about a suicidal family member

In cases where a person is a survivor of the suicide of a significant other, it may be useful to obtain support services to deal constructively with the loss. Unresolved grief can result in both medical and psychological difficulties down the road.

Fortunately, there are many sources of information about suicide prevention services. Residents of Connecticut can call Infoline. Below is a description of Infoline from its website at http://www.infoline.org/:

2-1-1 Infoline is an integrated system of help via the telephone - a single source for information about community services, referrals to human services, and crisis intervention. It is accessed toll-free from anywhere in Connecticut by simply dialing 2-1-1. It operates 24 hours a day, 365 days a year. Multilingual caseworkers and TDD access is available. 2-1-1 connects you to agencies and organizations near you that can make a difference. Dial 1-800-203-1234 outside of Connecticut.

There is also a national database of suicide hotlines online at http://suicidehotlines.com/ where you can simply click on your state and get a list of services. For those without a computer there is a 24-hour toll free number: 1-800-SUICIDE or 1-800-784-2433.

Below is a list of hotlines and crisis services that can assist suicidal persons. These are arranged alphabetically by city or town.

Ansonia Valley Mental Health Center 24 hours / 7 days (203) 736-2601 ext. 370

> Branford Harbor Health Services 24 hours / 7 days (203) 483-2630

Bridgeport Southwest Region: Serving Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, & Wilton

Greater Bridgeport Community Mental Health Center 24 hours / 7 days (203) 551-7507

Danbury Hospital 24 hours / 7 days (888) 447-3339

Dayville Serving Eastern Connecticut 24 hours / 7 days (860) 774-2020

> Derby Griffin Hospital 24 hours / 7 days (203) 732-7541 1-800-354-3094

East Hartford Serving North Central Connecticut

Intercommunity Mental Health Group 24 hours / 7 days (860) 895-3100

> Enfield Serving North Central Connecticut

North Central Counseling 24 hours / 7 days (860) 683-8068

Hartford Serving North Central Connecticut Mobile Crisis Service Capitol Region Mental Health Center 24 hours / 7 days (860) 297-0999 Hartford The Samaritans of th Capital Region 24 hours /7 days (860) 232-2121

Manchester Serving North Central Connecticut Genisis Center 24 hours / 7 days

Meriden Serving South Central Connecticut Midstate Behavioral Health System 24 hours / 7 days 1-800-567-0902 (203) 630-5305

> Middletown Serving South Central Connecticut Middlesex Hospital 24 hours / 7 days (860) 344-6496

Middletown River Valley Service 24 hours / 7 days (860) 344-2100

Milford Bridges website: www.bridgesmilford.org 24 hours / 7 days (203) 878-6365

New Haven Connecticut Mental Health Center 9 a.m. – 10 p.m. (203) 974-7735 (203) 974-7713 10 p.m. – 8 a.m. (203) 974-7300

New Haven Clifford W. Beers Guidance Clinic 24 hours / 7 days 1-888-97-VOUTH 1-888-979-6884

Norwich Serving Eastern Connecticut

Southeastern Mental Health Authority 24 hours / 7 days (860) 859-9302 Plainville
Serving North Central Connecticut
Wheeler Clinic
24 hours / 7 days
Helpline:
(860) 747-3434
(860) 524-1182
Community Response Team:
(860) 747-8719

Stamford
Southwest Region: Serving
Bridgeport, Darien, Easton,
Fairfield, Greenwich, Monroe,
New Canaan, Norwalk,
Stamford, Stratford, Trumbull,
Weston, Westport, & Wilton

Franklin S. DuBois Center 24 hours / 7 days (203) 358-8500

Torrington Serving Northwest Connecticut Northwest Mental Health Authority 24 hours / 7 days (888) 447-3339

Waterbury Serving Northwest Connecticut Waterbury Hospital Psychiatric Center 24 hours / 7 days (203) 573-6500

> West Mystic Contact of Southeast Connecticut 24 hours / 7 days 1-800-848-1281 (860) 848-1281

In addition, there are services that provide support groups to survivors of suicide:

Bridgeport Telephone Group (203) 372-5702

Darien Center for Hope (203) 655-4693

Wilton Therapist Led Group (203) 762-7804

Seymour (203) 264-5613

Managing the Acutely Suicidal Patient

By Bruce Gussin, PA-C, and Charles J. Morgan, M.D., Chairman Department of Psychiatry Bridgeport Hospital

man in his thirties is brought in to your ER by family. According to family members he has completely stopped eating, lays in bed all day - without sleeping- and appears to have lost all will to participate in any meaningful activity or conversation. When questioned it is elucidated from family that he was in an auto accident - for which he blames himself - in which his oldest son was killed. This event occurred approximately one week ago and in the following days he has become completely despondent and states only "I deserve to die for what I have done." The patient also exhibits consistent rumination. He plays the events of the accident over and over in his head and constantly seeks understanding of blame. Rather than accept that it was an unfortunate accident he seeks primarily to find a way to blame himself for the events. According to family they are unwilling to leave him unattended, even for brief moments, for fear that he will harm himself. The patient has loaded firearms in the home and has professed his intent to use them "to end my suffering." It is also stated that his father and male first cousin took their lives violently. Family reports that the patient has "always been a hard working, dedicated family man". He has never had any outpatient or inpatient psychiatric care and has never stated suicidal intention in the past.

The above scenario presents the clinician as well as the family members with many questions. The most important, of course, is "what do I do now?"

In providing some guidelines to the above question I would like to start out with some common background information on suicide. According to the CDC:

- Suicide took the lives of 29,350 Americans in 2000.
- More people die from suicide than from homicide. In 2000, there were 1.7 times as many suicides as homicides.
- Overall, suicide is the 11th leading cause of death for all Americans, and is the third leading cause of death for young people aged 15-24.
- Males are more than four times more likely to die from suicide than are fe-

males. However, females are more likely to attempt suicide than are males. 1999, white males accounted for 72% of all suicides. Together, white males and white females accounted for over 90% of all suicides.

• 57% of suicides in 2000 were committed with a firearm.

It is also important to understand that suicide is not only the product of extreme depression. Virtually all of the major categories of psychiatric illnesses can result in suicide as an endpoint. This list would include: depression, bipolar disorder, schizophrenia, substance abuse, as well as Personality Disorders and dementias. Ignoring the potential risk in non-depressed patients can have catastrophic results.

When faced with a suicidal patient it is important to have a clear understanding of the essential "do's and don'ts": Do:

Listen carefully to what patients or family members tell you:

- Are they hopeless or do they feel helpless?
- Do they feel others would be better off without them?

- Are they giving their possessions away?
- Are they assigning responsibility "You need to take care of your brother when I am gone."
- Do they perseverate on their suffering or ruminate about their losses?

All of these are essential characteristics of a patient at risk for self-harm. Further discovery of these elements of the patients illness serve as evidence of suicidality and will provide qualifiable markers of improvement when considering their safety as they begin to improve with treatment. Don't:

Minimize or Misunderstand the problem

- Assume they are not serious
- Leave the person alone
- Involve yourself in contracts of safety or secrecy
- Overreact or act shocked
- Threaten, challenge, or dare
- Attempt to involve moral/religious arguments

When initially evaluating a suicidal patient/family member/friend it is important to understand

see Managing on page 47

Interest Becomes Personal

By Emily Byrne, APRN **Norwalk Hospital**

uicide has been an interest of mine for years. It began as a fascination of the infernal madness and creative brilliance of writers such as Plath, Sexton, and Woolf. These writers, among many artists, died a self-inflicted death.

My interest became a personal, chilling reality three years ago. October 30, 2000 a close friend from high school killed himself by rope. The news surprised many, but shocked few. Beneath the surface of outward successes was a man tormented by dark moods and manic temperaments. He suffered and self medicated with drugs and alcohol. Family and friends reached out, but he slipped deeper into his private nightmare. At his funeral and the days and months that followed we wrestled with the sense of having failed.

Three months later my best friend from college ended his life by bullet. The call from his mother came three days after his 27th birthday, forty-eight hours after I had last spoken to him. I replayed our last conversation over and over searching for clues. His final words to me, 'never sacrifice your creativity for security.' I promised and we said goodbye.

The emotional weight of the experience broke me. Time seized. I was paralyzed by pain, suffocated by guilt, and lost in a chaotic hopelessness that permeated everything. My hollow existence became one of isolation and fragmentation. Each day my breath grew more shallow and sour. I felt life bleed from my necrotic body. Fortunately my unraveling and plunge was quick. Recovery was painfully slow. It was over a year before I felt the wings of hope again. Time eases the hurt, but the missing remains. The hole burned in the hearts of the bereaved aches with a chronic, corrosive pain. Haunted by the agonizing question, why, we dig for answers. Some dig through memories, sifting through pictures, belongings, and letters. I dig with my pen.

As clinicians we have a great deal of knowledge of psychopathology and sui-We understand the black and white statistics. Suicide is a national health problem that claims the lives of 30,000 people each year. Each day approximately 80 Americans die a suicidal death. This equates to 1 person every 18 minutes. It is the third leading cause of death of young people and the second among college students. We know that most suicides occur in people suffering from mental illness and substance abuse. We know that that the highest risk populations are the elderly (65+ years) and the young (15-24 years). There is a gender bias with women 3-4x more likely to attempt suicide and men 4x more likely to kill themselves. Statistics reveal a seasonal variation with late spring and summer having the highest rates of suicide. We know that attempted suicide is the single most powerful predictor of subsequent suicide. Despite all that we know, we are left asking why?

The depth of psychological pain and despair that closes the mind and heart to life is a private experience. Sufferers experiencing that extent of hopelessness may isolate, making a clinical snapshot difficult. Assessment of suicide risk can be captured at every clinical encounter. Directly asking about suicidal thoughts and intent, evaluating levels of agitation and anxiety, inquiring about sleep disturbances, and recent causes of stress can help identify a client at risk. Some segments of the population's suicide rates have dropped, while others continue to rise. As clinicians and as a nation we need to not only ask why, but how can we make a difference.

Managing from page 46

the varying degrees of care available. Understanding that suicidal persons present with a variety of presentations is often a mystery to the lay person. Should we worry more about the emotionally labile screamer or the quiet/withdrawn sleeper? The answer is that a suicidal threat needs to be taken seriously despite the presentation. The first step can be to continue to attend to the person while contacting their private counselor or physician or it could be an immediate trip to the ER. The benefits of hospital care are multifold. First and foremost would be the enhanced safety that a monitored unit can provide. More important though, is the wide range of talents and backgrounds that can be provided by the interdisciplinary nature of the inpatient unit. Often the first step in fighting depression is the bond formation that can occur between patient and caregiver whether it be Nursing, Medical Team (Psychiatrist, Physician Assistant, Nurse Practitioner), Recreation therapy, Social Work or other patient.

The most important aspect of understanding when a patient can be discharged from care, safely return to their environment, is this information we gather initially. Since the presentation of suicidal patients vary so widely it is crucial to be able to see what has changed which would represent that they are no longer a danger to harm themselves. In the above case presentation it was our belief that once his constant rumination was alleviated the patient would no longer represent a risk. In other patients it could be the cessation of auditory hallucinations or an improvement/change in their home situation. Either way the most important element is change. For this reason it is essential that the treatment team is constantly evaluating the patient for suicidal risk, not just at admission and discharge. Although we can never guarantee that a patient is absolutely no risk to themselves, by consistent evaluation with an eye toward changes in presentation over time, we can present our safest estimation and minimize tragic outcomes.

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Why Do People Kill Themselves?

By Sigurd Ackerman, M.D. President and Medical Director Silver Hill Hospital



Sigurd Ackerman, M.D.

hy would someone commit suicide? There are many answers to this question but, for my purposes in this brief article, they fall into two very different groups. A few people end their lives as part of a more or less rational decision when, in the course of a terminal illness or other dire circumstance beyond their control, they find no prospect for an acceptable or even bearable quality of life.

However, the vast majority of suicides occur as part of a mental illness. This, of course, is the group that is of most interest to psychiatrists and other mental health workers. The notion that suicide is almost always related to a mental disorder is controversial but nonetheless one of great significance. If the state of mind that prompts the impulse to end one's life is part of a reversible episode of a mental disorder then the suicidal state of mind will go away when the disorder is successfully treated.

The "mental disorder" perspective does not mean that other factors are not important. For example, a

family history of suicide seems to increase the risk of suicide independently of mental disorders. Genetic factors may be important independently of mental disorders. And, as I said initially, for some the decision to end their lives also seems to be independent of any mental disorder. But starting with the assumption that the proclivity to harm oneself is part of a mental disorder maximizes the chances of preventing self harm by maximizing the chances that the person will soon have a change of heart.

However, this last statement by itself raises more questions than it answers. What are the mental disorders that are associated with suicide? Can one predict in advance which person with one of those disorders will actually attempt suicide? Is the assessment of suicide risk the same for all disorders?

For convenience we can talk about four groups of mental disorders that are associated with suicide. This list in not exhaustive but it helps in organizing our thinking about the topic. The groups to which I am referring are the mood disorders (depression and bipolar disorders), schizophrenia and other disorders which cause psychosis, substance-abuse disorders and certain personality disorders.

Most persons who commit suicide do so in the midst of an episode of depression. In addition to its affect on mood depression has a profound effect on cognition – the way we think. Thoughts in depression often turn to guilty self recriminations, the idea that one does not have intrinsic worth and the idea that there is no hope for a brighter future. In this context, the idea of ending one's life can become appealing.

Evaluating the suicide risk in a depressed person is based on a careful assessment of such thoughts with special attention paid to how the person views suicide and whether he or she may have made plans to end his/her life. (There is no basis in fact

for the belief that asking a depressed person about suicide may plant an idea that wasn't there already there. Conversely, a person's denial of suicidal intent does not mean he won't attempt to kill himself). In addition, information about other risk factors is extremely important, including a past history of suicide attempts, a history of suicide in first degree relatives, current substance abuse, a history of childhood sexual abuse, impulsivity and aggressiveness as prominent personality traits and lack of social and family supports.

When the consideration of the depressed person's current mental state and these risk factors suggest an increased risk for suicide, hospitalization is often the safest course. With proper treatment there is a high likelihood of recovery from depression and, with that, a dramatic change of mind about suicide. However, this recovery takes time and, with hospitalization, one buys time.

In episodes of psychosis, such as in an acute exacerbation of a schizophrenic disorder the situation can be quite different. The patient might experience voices that tell him to kill himself or have a delusional thought which includes the notion of self harm. In such situations the patients potential for actual self harm is much more unpredictable and therefore more difficult to assess with a risk-factor approach. If such symptoms cannot be changed very rapidly by treatment with neuroleptic (antipsychotic) medication, most mental health workers would move for hospitalization to keep the patient out of harms way until symptom remission does occur.

Substance abuse disorders have an independent risk for suicide, probably because acute intoxication can cause a rapid change mood in association with changes in thinking and in judgment. In addition when an acutely intoxicated person dies in a fatal accident, such as a one-car collision, it is often difficult to determine the extent to which the fatality was partly intentional.

In certain personality disorders, such as the borderline personality disorder, the patient has a greater proclivity for attempting suicide, even if ambivalently. This, too, is a serious situation because some of those attempts are successful. However, treatment is difficult and requires a change in the person's stable traits, as distinct from the treatment of a transient, episodic state disorder such as depression. Long term treatments of patients with personality disorders typically focus on learning to use new coping mechanisms to deal with anger, loss, depressed mood, a sense of emptiness or sensitivity to rejection.

Should we always start with the assumption that the wish to kill oneself is a temporary, reversible aberration? A dramatic argument for why we should can be found in an article by Tad Friend in the October 13, 2003, issue of New Yorker Magazine. Friend gave a short history of suicides carried out by jumping from San Francisco's Golden Gate Bridge. Astonishingly, these occur on average about once every two weeks - or a total of more than 1200 suicides since the opening of the bridge in 1937. Of this vast number only 26 persons are known to have survived. Friend interviewed those he could find, two of whom gave chilling accounts of regretting their decision to jump as soon as they left the bridge. Conversely, he reports a study of 515 persons who were thwarted in their attempts to jump. In a follow up of, on average, 26 years, 94 per cent of the wouldbe suicides were still alive or died of natural causes.

The main point I am making is that the wish to kill oneself is most often transient and reversible. Whether you start by identifying mental illness or by identifying suicidal intent the interface between them provides the greatest opportunity to offer help and perhaps save a

Mental Health News Understands That The Holidays Can Be A Difficult Time
If You are Feeling Alone and Hopeless: Don't Be Ashamed To Ask For Help
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Suicide: **An Addictive Behavior**

By Robert M. Lichtman, Ph.D., DAPA **Rockland Psychiatric Center**

aniel was intent on killing himself. He threatened his outpatient treating team and his family, that if he did not receive a prescription for Ativan, a highly addictive anti-anxiety drug, he was going to drink himself to death. In order to prevent this, his family had taken him to a psychiatric emergency room, where he was hospitalized as a danger to himself. Once again he began to demand that the ward psychiatrist give him the drug. As with most chemically dependent patients receiving efficacious treatment, he did not receive it. He then persuaded his family into taking him home, promising that he would not harm himself. Unfortunately they believed him and came to the hospital signing him out AMA (Against Medical Advice). Once home and out of his family's sight he secured the anti-anxiety drug on the street, bought a liter of vodka, rented a room in a local motor inn and successfully committed suicide. The combination of the anti-anxiety drug and the vodka proved to be quite lethal, and he knew it would. Following



Robert M. Lichtman, Ph.D.

a psychological "autopsy" and a root cause analysis it was determined that Daniel "was going to do what he was going to do," the culpability was his own. I have often reflected on Daniel's case and his drive to kill himself, thinking "short of locking him up, and throwing away the key," did we do everything clinically possible to prevent that suicide? The question haunts me to this day. The concepts of free will and selfdetermination are challenging when someone takes their own life.

see Addictive on page 53



American Association of Suicidology

THE LINKS BETWEEN DEPRESSION AND SUICIDE

- Major depression is the psychiatric diagnosis most commonly associated with suicide.
- About 2/3 of people who complete suicide are depressed at the time of their deaths.
- One out of every sixteen people who are diagnosed with depression eventually go on to end their lives through suicide.
- About 7 out of every hundred men and 1 out of every hundred women who have been diagnosed with depression in their lifetime will go on to complete suicide.
- The risk of suicide in people with major depression is about 20 times that of the general population.
- People who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.
- People who have a dependence on alcohol or drugs in addition to being depressed are at greater risk for suicide.
- People who are depressed and exhibit the following symptoms are at particular risk for suicide:
- 1. Extreme hopelessness
- 2. A lack of interest in activities that were previously pleasurable
- 3. Heightened anxiety and/or panic attacks
- 4. Global insomnia
- 5. Talk about suicide or a prior history of attempts/acts
- 6. Irritability and agitation

Hudson from page 10

is committed to supporting community rehabilitation approaches that are innovative and have proven to make a difference in the lives of individuals with severe mental illness. This commitment is reflected in a mindful way through OMH's support of evidence-based practices such as supported employment. Research has shown that rapid integration into community vocational settings, with appropriate supports, has a major impact on an individual's recovery. Best practices are one of OMH's basic tenets for service enhancement that also includes Accountability and Care Coordination - the

Empirical research indicates that the supported employment model of vocational rehabilitation has strong positive outcomes for individuals with severe mental illness. The key components of this model are: rapid job searches and placement, employment settings based on recipient choice, follow along supports that are unlimited, integration with the mental health clinical team and a strong provider commitment with the understanding that competitive employment is an obtainable goal for anyone with a desire to work. The emphasis is not on longterm prevocational readiness develop-

Supported employment, as an evidence-based practice, allows for service provision to be benchmarked in a more objective fashion. Fidelity to the model design, for any supported employment provider, can be measured through instruments like the Quality of Supported Employment Implementation Scale (QSEIS).

The efficacy of supported employment has been well documented. Treatment designs in controlled settings have proven to work. The effectiveness of these services, in the community, has been unfolding and the results are very positive. The latest comparable supported employment data indicates that integrated placement rates, for individuals in SE programs within the Hudson River region is 39% (statewide 28%). OMH's Hudson River region extends from Westchester County north to Warren and Washington Counties in the Adirondacks. There are two milestone project contractors within this region, Gateway Community Services and Westchester MHA. Placement rates, after screening, for these two programs averages 60%. Employment positions

include sales associate, home health aide, junior machinist, tutor, cashier, dietary aide, library assistant and substitute teacher. Mary works approximately 30 hours per week. The regional average work week is just over 24 hours.

The central theme that weaves its way through all of OMH's service delivery designs in the Hudson River region and around the state is the value of hope and recovery. Recovery is a living process at the Liberty House Foundation in Glens Falls, NY. Liberty House is a not-forprofit clubhouse modeled after Fountain House in NYC. Every day members and staff work side by side to facilitate the operation of the clubhouse. Along with a mobile work crew and a transitional volunteer program, Liberty House offers transitional, assistive competitive and independent employment choices for members.

The stabilizing effects of Liberty's clubhouse design equates to an increase in job tenure for program recipients. On average, members are employed in integrated, competitive settings for a period of 72 months. The average work week is 34 hours. Liberty House's placement rate is 74%.

Marie, a clubhouse member, has been in her current assisted competitive employment (ACE) position for six years now. She originally went back to the job that she was discharged from prior to the onset of her mental illness. She is now a registrar for patient access in the emergency room of an area hospital. Marie values the ongoing, unlimited support that the clubhouse provides. Previous attempts at complete independence resulted in repeated hospitalizations. A placement manager sees her at work approximately two times each week. She is also an active member at the clubhouse which she says, "recharges her batteries".

Blended mental health services and a supportive clubhouse model are just two examples of effective supported employment programs in the Hudson River region. These programs are making a difference. John, a former carpenter for 27 years who was placed by Gateway's milestone project at a local building supply company, put it best when he said, "Work makes me feel more normal, it makes me feel like a human being."

You may contact Jack Smitka at the NYS Office of Mental Health, Hudson River Field Office at (845) 454-8229.

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Youth Suicide: Building Bridges Through Community Outreach

By Ari Kellner, Psy.D. The Mental Health Association of Westchester

uicide ranks as the third leading cause of death for young people (ages 15-24); only accidents and homicides occur more frequently. Approximately 12 young people between the ages of 15-24 die every day by suicide. In 1998, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined (Surgeon General, National Statistics). Suicide rates of 15-24 years olds are 300% higher than those of the 1950's, and have remained largely stable at these higher levels between the late 1970's and the mid 1990's. Suicide rates of children between the ages of 10 to 14 years increased 99% between 1980 and 1997, with slight declines in recent years. More troubling than these statistics is our knowledge that there are far more suicide attempts and gestures than actual completed suicides. Nationwide, nearly one in five high school students have stated on self-report surveys that they have seriously considered attempting suicide during the preceding 12 months (American Association Suicidology).

Why would so many young people end their lives? The answers are complex and elude our desires for simplistic, clear, cause and effect relationships. Instead, suicidal behavior is the end result of an interaction between multiple factors, which may be of a psychiatric, social, and environmental nature.

Stillion, McDowell, and May have outlined their suicide trajectory model which suggests that there are four major categories of risk factors that contribute to suicidal behavior at every age: biological, psychological, cognitive, and environmental. Each of these categories of risk factors may directly influence suicidal ideation and may affect other categories of risk factors. For example, having a biological inclination toward depression can directly affect suicidal ideation and, at the same time, cause a person to develop low self-esteem and to interpret environmental events in a selectively negative fashion. Likewise, poor environmental conditions, such as an abusive or neglectful home, can elicit suicidal ideation and also may be a source of low self-esteem. Some of the strongest risk factors for attempted suicide in youth are depression, alcohol or other drug use disorders, aggressive or disruptive behavior and access to lethal means of self-harm.

Understanding these risk factors can help dispel the myths that suicide is a random act or results from stress alone. It is also important to note that one risk factor is seldom sufficient to trigger suicidal behavior; often a young person exhibits multiple risk factors that are clear warning signs of potentially dangerous behavior. For example, a high school student who feels depressed, is abusing alcohol and drugs, has a history of very impulsive behavior, and has access to highly lethal methods to attempt suicide is at much greater risk than that same student who is feeling depressed without the other risk factors. Fortunately, many risk factors can be reduced or moderated by protective factors.

One of the most important protective factors is helping young people receive the appropriate clinical care for mental, physical, and substance abuse disorders they may be experiencing. This process is greatly aided when youth have easy access to a variety of clinical interventions and feel supported by their community and family for seeking help.

One vital way of developing easy access to clinical care is through an open and collaborative relationship between community mental health providers and the surrounding schools, faith-based organizations, healthcare professionals, and other public and private community partners.

Through successful collaboration we begin to ensure that our prevention plans are comprehensive enough to address the complexities of the problem; promote collective ownership of the problem, engage organizations that may not have considered suicide prevention within their purview, avoid duplications of efforts, and leverage resources to fund projects that will address the greatest need and make the most impact (U.S. Dept. of Health, Sybil K. Goldman). In addition, youth who are known to be at risk often receive services and help from a variety of agencies. Through interagency communication service delivery can become more integrated and less fragmented. Consistent contact between agencies can clarify what other service providers are doing, what services are already in place, or what information is already available to help understand a person's needs.

Schools can play a unique role in this process. As several researchers have pointed out, suicidal children and adolescents are much more likely to come in contact with potential help in the school environment as opposed to other community settings (NIMH, CDC, Surgeon General). Frequently, a child's problems, particularly those related to academics or the peer group, are more evident in the school than in the home. In addition, the home situation may be dysfunctional; while not necessarily a direct cause of suicidal behavior, the possibility of help in that setting is greatly reduced.

Some of the areas that may be addressed through community collaboration may include the following:

• Promote awareness that youth suicide is a public health problem that is preventable.

- Develop broad-based support for youth suicide prevention.
- Design and implement strategies to reduce the stigma associated with being a youth consumer of mental health, substance abuse and suicide prevention services.
- Identify, develop, implement and evaluate youth suicide prevention programs.
- Promote efforts to reduce access to lethal means and methods of self-harm.
- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Develop and promote effective clinical and professional practices.
- Improve access to community linkages with mental health and substance abuse services.
- Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in media and entertainment.

• Promote and support research on youth suicide and youth suicide prevention

The pain and loss behind the previously mentioned statistics are why we need to act now. We must accept that the problem of youth suicide is too large to handle alone and many of our answers begin through partnership. The following are a list of informative suicide websites:

American Association of Suicidology www.suicidology.org

American Foundation for Suicide Prevention www.afsp.org

Mental Health Association of Westchester www.mhawestchester.org

National Strategy for Suicide Prevention www.mentalhealth.org

Suicide Hotlines www.suicidehotlines.com

Ari Kellner, Psy.D. is trained as a School/Clinical Psychologist. He works for the Northern Westchester Counseling Center in Mt. Kisco, NY and has a private practice in Katonah, NY.

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For Information and Brochure:
Mark Gustin
Conference Chair

(516) 791-5289

Suicide And Mental Illness

By Martin Gittelman, Editor International Journal of Mental Health

ne of the major causes of premature death is suicide. It is good that Mental Health News is drawing attention to the issue of suicide among persons with mental illness. Relatively little attention has been paid to the phenomena of preventable and premature death among persons with mental illness nor to the risk factors which increase morbidity and mortality. The President's New Freedom Commission Report has drawn renewed attention by citing that some 30,000 persons commit suicide and each year 650,000 persons require emergency care following a suicide attempt. While the annual figure of 30,000 who die from suicide is the same as the number who die from HIV-AIDS, suicide has received much less attention in the me-

We've known for many years that persons with mental illness die prematurely because of many and complex factors. Cliff Levy in his Pulitzer prize winning recent series on nursing homes in NYC found that persons with severe mental illness died at an average life expectancy of 58 years, many as the

result of suicide. A review of the literature shows that persons with mental illness commit suicide at a rate at least 9 times more than persons without mental illness (Harris, C. and Barraclough, B.M. Suicide as an outcome for mental disorders, British Journal Psychiatry, 170,1997). Mental illness need not and should not be fatal. Yet the evidence is clear that these disorders are associated with risk factors which lead to premature death and suicide. Cassadebaig (1999, L'Encencephale, 25, 329-37) has stated that studies of mortality among persons with mental illness are good indicators of the quality of care they receive or do not receive.

As we seek to understand the factors which make for high suicide rates and short life expectancy among persons with mental illness we need to look at known factors which make for shortened life. M.Harvey Brenner in his classic study on the consequences of unemployment found that for every 1% increase in unemployment there was an increase of 10,000 deaths from a myriad of proximal causes, including suicide. Unemployment, homelessness, tobacco addiction, alcoholism, substance abuse, poverty are all factors associated with

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Losing Weight: It's A Mind Thing!

Marypat S. Hughes M.S.,R.D.,CD/N Spokesperson for the ADA

re you turning to food because you are feeling alone or terribly lonely? Is food the only thing that makes you feel calm, even happy? You are not alone if you are eating out of control. Many people eat when they are under extreme stress. Some people may agree that all you have to do to stop the weight gain is put down the fork. Fortunately, the weight gain that comes from overeating can be prevented. The secret is to understand the effect stress is having on you so you can adjust your lifestyle and eating habits-accordingly.

Sixty one per cent of U.S. adults are overweight. Research is starting to show that the greatest barrier to weight loss is not your genes or constant craving for carbohydrates-it is your mind set.

Let us try to leave the old mind set behind and recognize the unhealthy way we eat or our weight will continue to grow. Luckily, it isn't tough to reverse the process. You need to set limits regarding food and you need to nurture yourself.

Experts have made it clear that as our weight increases we are also increasing the odds of being at risk for diabetes, high blood pressure and heart disease. Very often our self esteem topples because we lose our self confidence to break free of the fattening mind set. We feel inadequate about being able to make healthy food selections.

Many people have found ways to successfully manage their mental illness. In order for success, whether it is for weight loss or stopping further weight gain challenging shifts must take place. To break out of an unhealthy situation we all need a little direction and clear goals to move to a more positive place.

Secrets to Winning The Mental Game

First, set attainable daily goals. Eat five or six times a day to avoid feeling hungry. Focus on including fruits, vegetables and complex carbohydrates, which help you feel full. Do not make unreasonable demands on yourself. Set reasonable goals and be gentle with yourself. Be sure to include exercise. If you achieve your small goals you will feel good about yourself. When we try to take big steps beyond our capacity relapse tends to occur. Try not to be hard on yourself and tell yourself that you can only do so much and try to do things that are good for you.

Self acceptance is important. Feel good about who you are. Repeat daily affirmations such as "I like myself" and "I am a worthwhile person". Once you accept yourself, you stop blaming others and you can begin to take control. Break the old patterns by keeping track of how often you eat and what you eat. Jot down times during the day and night when you are eating. List all the extras like butter, seasonings and toppings-do

not forget to include drinks and snacks while watching TV. Become aware of portion sizes and read labels so you are aware the portion size of your favorite snacks.

Confusing foods with feelings (emotional eating) is very common. Most of us do not eat just for nutritional replenishment. For most of us meals are indicators of milestones in our days. We all have strong feelings about foods we like or dislike. Foods are part of religious rituals, celebrations and social activities. Eating can also be triggered by a single emotion or several. Eating can be triggered by confusion or emotional distress. Ask yourself, "what am I feeling?" Am I stressed, bored or feeling unloved?

For some people an emotion may trigger the craving of certain types of food. Keeping a food diary may be helpful information in identifying your eating patterns. After you have this information you will be able to assess where you need to focus your attention. Do you find that you responded to emotional arousal or are you not sure what you were feeling?

Awareness of emotional eating patterns makes control straightforward. You will become aware if you eat just because food is always around you. You may begin to stop and become aware if you are eating because you are hungry or if you are eating out of bad habits. Listen to your emotions when they come up. Instead of turning to food, try and relax with yoga or going for a walk.

Be respectful of your body. Value it, exercise it and choose healthy foods to nourish it. Try not to reach for food in order to push away painful feelings. To face such emotions you may want to enlist the aid of your psychiatrist. You need support and the support can teach you to be self-reflective and to come up with solutions other than food. After you realize the problems, be assertive and come up with a plan to put yourself first. Do something kind for yourselfmake up your mind to take good care of yourself. Figure out what is normal for you and stop eating when you are full. If you do not really enjoy what you are eating, do not feel like you have to finish it. It is okay to throw food away.

Change your behavior to include more fruits and veggies. Monitor your changes. Realize that it will take some time to adjust. Focus on planning healthy meals and snacks. Resist skipping meals—research shows you tend to overeat if you eat when you are over hungry. It takes four hours for your body to digest an average meal or snack. If you are eating more frequently, you are eating too much. Too much food gives you extra calories which leads to weight gain.

see Mind Thing on page 56

Addictive from page 50

Running on Empty

Daniel was neither religious nor spiritual. Church and self-help programs held little value for him. The central activity in his life was to remain in the altered sense of consciousness produced by the psychoactive properties of an anti-anxiety drug. When the drug was not available, alcohol took its place not his drug of choice, Ativan was. Alcohol drove him into misery and made his hunger for Ativan worse. Daniel in an alcohol intoxicated state was literally hopeless, hapless, and helpless. He was running on empty, unable to fill himself, and the alcohol was a poor second place substitute. It was the lure of Ativan that kept him going. He could not tolerate the protracted withdrawal enforced by the controlled environment of a hospital ward or a locked rehabilitation program. He went through countless detoxification and rehab programs, both inpatient and outpatient. His comfortable state was his addicted state, and without the anti-anxiety drug in his system he was very uncomfortable. As with many substance dependent people his tolerance increased exponentially to a point where he required four times the dosage indicated for someone with an anxiety disorder. Other medications were tried, all to no avail. They only made him tired and produced sleep. Once awake the craving returned twofold. He could not live in his skin; the pain was too great. The addiction to the drug was now turning towards the drive towards death. He saw his life ending as the only way out of his misery: it had become an addiction to suicide.

When Ingestive Addictions Become Process Addictions

Specialists in addictive disorders usually separate behaviors that involve the administration of substances into one category and others like pathological gambling, shoplifting, exercising, the internet, and sexual compulsivity into another. Hence the terms ingestive and process. They are not mutually exclusive, as people engage in both and at times simultaneously. I prefer to call the latter "Addictions Without Substance," although both have a payoff in the form of physiological, psychological, and sociological reinforcement. Anecdotally, I have seen a number of cases where the person's life ended in an intentional suicide, either by design, as in Daniel's case, or by moral deterioration, to a point where an "accident" takes the person's life. When there is literally nothing more to live for other than seeing oneself being strangled and falling deeper into an abyss, suicide is no longer seen as an option. The drive towards dying takes on all of the properties of addictive behavior, especially the obsessive and compulsive components. It is no longer seen as some clinicians say "a permanent solution to an otherwise temporary problem," it becomes the "solution" itself. The drive towards oblivion is all too powerful.

Dr. Lichtman is a specialist in the assessment and care of people who have co-occurring emotional and substance use disorders. He is a faculty member at John Jay College of Criminal Justice and the Ferkauf Graduate School of Psychology, Yeshiva University, Albert Einstein College of Medicine.

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increased risk for illness, premature death and suicide.

The recent President's Freedom Commission Report on Mental Health has informed us about some of the reasons for increased morbidity and mortality. The Commission found that only about half the people who require assistance are receiving such assistance. In the Commissions' words, our mental health delivery system is in "shambles". The Commission's Report of 30,000 suicides with 90% associated with mental illness - a "wake up" call to action, yet the report seemed to have attracted little editorial comment.

Since the recession by President Reagan of the Mental Health Systems Act of 1979 at the time of his inauguration and the subsequent de-funding and closure of Community Mental Health Centers we have seen increased problems with our mental health system. While there are some fine examples of comprehensive care, treatment and rehabilitation, "getting the government off the backs of the people" and the introduction of managed care has failed to fulfill the promise of improved care which could stem high mortality among persons with mental illness. We now spend more on treatment and care than any other country in the world, yet our suicide and attempted suicide rates are among the highest in the world.

What can and should be done about the problem of suicide and premature death among those with mental illness? In recent years we have seen the growth of the family and mental health consumer movement along with other advocacy groups such as the Mental Health Association and American Association for Psychosocial Rehabilitation. Such groups have yet to truly fulfill their roles as advocates to press for improvements in the organization and delivery of mental health care. We need to do a better job to deal with this problem of suicide and premature death among persons with mental illness.

Get Your Message Out! Advertise in Mental Health News

New Internet Dating Site For Adults with Mental Illness

Staff Writer Mental Health News

or the heroic men and women fighting mental illness in this country, NoLongerLonely.Com is filling a need and offering welcome relief with a safe, secure, and free way to find companionship. The billion-dollar online dating industry is finally reaching those who need it most: the mentally ill.

Webmaster James Leftwich understands the trials and tribulations of managing a mental illness. Since being diagnosed with Schizoaffective Disorder in 1992, Mr. Leftwich has secured a Bachelor's Degree and a Master's Degree and is now pursuing a career in librarianship. Confident that there were thousands of other such "recoveries" across the United States, Leftwich launched NoLongerLonely.

According to Mr. Leftwich, "Social isolation is a hallmark symptom of mental illness. The general public is basically indifferent and often hostile to those struggling to re-integrate with society. In my experience, most mentally ill people tend to group together but

finding each other often poses a difficult challenge. It is my hope with this website that finding and securing meaningful relationships, whether friendship or romance, will be easier for those who sign up for membership. My goal is to literally make those with mental illness 'No Longer Lonely'."

NoLongerLonely offers a broad array of features that the larger dating sites have made standard such as anonymous emailing, photo upload, proximity searching, detailed matching criteria, Email notifications, a chat room, and soon a section for members to submit original articles, essays, and artworks.

Leftwich has made guaranteeing the privacy and anonymity of his users a top priority, "It is understandable that users will be wary of disclosing they have a mental condition. For this reason all contact between users is under the heading of a fictitious username. Their only real identifying mark is their photo if they choose to upload one. It is also important to remember that anyone using the site also has a mental condition."

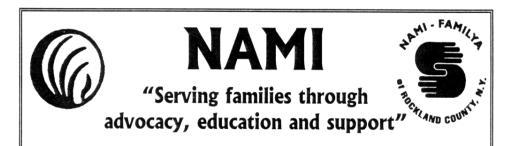
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Helping Families from page 27

In a situation of this type, a family member can become frightened and may even feel that they have somehow hurt the patient and caused the suicide.

It may feel unacceptable to express angry feelings or personal hurts at a time like this. Actually, a clear, honest expression of our feelings can work to relieve and soothe the situation in many ways. Otherwise this anger is projected towards other family members, or towards ourself causing illness, separation and many other harmful consequences.

Families often react by bottling up their feelings and trying to hide how upset they are. In the long run this is detrimental. It gives less and less reality to the situation, creating only distance. It is healthier to acknowledge and carefully express resentment or disappointment.

We can express our personal reactions without casting blame. Just simply communicate what you are feeling now.

Say, "This is how I am feeling now. This is what I'm thinking". One takes responsibility for one's own feelings and thoughts and does not imply that another caused you to feel these feelings.

No one causes you to feel what you feel. Things out there happen, and you can react to them in many different ways. You are not necessarily responsible for what has happened, but for how you are responding to it. And what you choose to do with it.

Relinquishing Blame

Family members (especially children) must be helped to see that their feelings did not injure their family member. The other person's suicide is never caused by them.

Most of the time we feel responsible for another's pain. This kind of discussion is heard frequently:

"If only we had done something differently, this wouldn't have happened. We didn't do enough. I knew it all along, but I was afraid to take a stand. We all failed. It's as simple as that."

Family members, friends and lovers who are filled with unacknowledged anger and self-blame often project these feelings onto one another. They constantly find fault with everyone, and create a difficult atmosphere. These individuals simply must be helped to acknowledge and accept their own feelings.

In such a case, we may greatly help these individuals by telling them that they are not to blame for what is going on. It is surprising how much this may calm them down. Of course they may need to hear it over and over again.

Sometimes this kind of opening will help individuals express other feelings to you as well. Just listening to and accepting their feelings will help relieve them of self-blame and guilt. It is not necessary to offer directives of any kind. Simply by being able to see that others accept them dissipates a lot of tension .

Casting blame happens so often that it merits real examination. Often it grows into a gnawing guilt that persists for years on end. The deep sense of not having done enough, not having been able to save a loved one, leads many widows to die within a year of their husband's death. It also can lead to major, unnecessary surgery. We may not feel we deserve to live happily since our beloved is gone. Guilt after death is just overwhelming.

In the case of a child dying in the family, spouses usually blame each other. All the times they did not love enough now appear in front of their eyes to be reckoned with.

"I just couldn't look at my husband after Tommy was gone. I kept feeling he was blaming me, thinking if I had only been a better mother, more patient and caring, this never would have happened. I kept wondering if he thought Tommy might have wanted to die. Neither of us could part with what was left of his bicycle. Even though the other children desperately needed our family to remain together, my husband and I separated that year. We just couldn't take it."

Blame cries out to be looked at and understood as a perfect example of our own lack of comprehension of loss and misplaced sense of responsibility.

Families need to realize that they are not and never have been in control of the patient's life. No matter how much they care for the patient, ultimately each person must answer for themselves.

Helping Each Other Heal

As family members attempt to cope with this event, one member sometimes becomes so identified with another that they become confused about their differing responses and needs. They believe everyone must grieve in the same way, or handle the situation the way they do, otherwise they are cold hearted. That person may have no real idea of what the other person is going through. It may be impossible for them to realize that the other person is truly different. They may distance themselves from their family member; at a time when the other person needs them greatly.

In these cases it is good to focus upon the ways in which one family member is different from the next, and has different ways of handling their loss. This gives everyone room to be themselves and have their own particular responses.

So many of us are busy giving to others that which we ourselves truly would like to receive. We can't give it to ourselves, but we can give it to another. Then we wait to get it back from them. We may end up waiting a very long time.

When we can give to ourselves directly, it is much easier to see what the other truly needs and give it to them.

Giving Each Other Room to Grow

A suicide in the family can destroy us, but it can also make us stronger and wiser as well. There is a choice to be made. When we see other family members in a negative light after this, that is exactly how they will begin to feel around us. The more negative the person seems to us, the worse they will begin to feel. It is as though our very perception and image of them were being transmitted. We may be ignoring the part of the individual that is healthy and strong.

The more attention you give one aspect, the more it blooms under your eyes. When family members start to become

see Helping Families on page 58



Creating Community

- Human Development Services of Westchester serves adults and families who are recovering from episodes of serious mental illness, and are preparing to live independently. Some have had long periods of homelessness and come directly from the shelter system
- In the Residential Program, our staff works with each resident to select the level of supportive housing and the specific rehabilitation services which will assist the person to improve his or her self-care and life skills, with the goal of returning to a more satisfying and independent lifestyle.
- The Housing Services Program, available to low and moderate income individuals and families in Port Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.
- Hope House is a place where persons recovering from mental illness can find
 the support and resources they need to pursue their vocational and educational
 goals. Located in Port Chester, the Clubhouse is open 365 days a year and
 draws members from throughout the region.
- In the Case Management Program, HDSW staff provides rehabilitation and support services to persons recovering from psychiatric illness so that they may maintain their stability in the community.

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Gene from page 9

within-gene modifications being important in each affected individual. This is also probably the first report of a modification in a transporter gene resulting in a gain rather than a decrease in function," said NIMH Director Thomas Insel, M.D.

SERT allows neurons, platelets, and other cells to accumulate the chemical neurotransmitter serotonin, which affects emotions and drives. Neurons communicate by using chemical messages like serotonin between cells. The transporter protein, by recycling serotonin, regulates its concentration in a gap, or synapse, and thus its effects on a receiving neuron's receptor.

Transporters are important sites for agents that treat psychiatric disorders. Drugs that reduce the binding of serotonin to transporters (selective serotonin reuptake inhibitors, or SSRIs) treat mental disorders effectively. About half of patients with OCD are treated with SSRIs, but those with the hSERT gene defect do not seem to respond to them, according to the study.

Any vulnerability to OCD from gene effects most likely interacts with events in the environment like stresses, other factors like gender, and treatments, Murphy said. By examining the serotonin transporter gene's mutation and flawed regulation in individuals with OCD, the new research provides insights on transporter function and on the consequences of the variant, which may lead to tests to identify and treat mental illness.

A related study in the August 2003 Molecular Pharmacology tested consequences

of the hSERT variant. The report is considered the first to identify a coding mutation in a transporter linked to a psychiatric condition. Researchers found that the I425V mutation of hSERT increased the transport activity of this protein, capturing more serotonin and most likely reducing effects at the receiving neuron's receptors, outperforming the common transporter. The mutant molecule was not regulated normally and did not respond to cell signals that activate the common form of the transporter. Gary Rudnick and Fusun Kilic, Yale University School of Medicine, with Murphy at NIMH, conducted this research, which was funded by the Rockefeller Brothers Fund, the National Alliance for Research on Schizophrenia and Depression, and the National Institute on Drug Abuse (NIDA).

Participants in the study published in Molecular Psychiatry were: Norio Ozaki, Fujita Health University School of Medicine, Toyoake, Aichi, Japan, whose early work on the project was supported by awards from the Intramural Programs of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and the NIMH; David Goldman, NIAAA; Walter Kaye and Katherine Plotnicov, University of Pittsburgh Medical Center and Western Psychiatric Institute and Clinic; Benjamin Greenberg, Butler Hospital and Brown University School of Medicine; Jaakko Lappalainen, Yale University School of Medicine; and Gary Rudnick, Department of Pharmacology, Yale University School of Medicine; Dennis Murphy, NIMH Laboratory of Clinical Science.

Parity from page 8

- discriminatory insurance coverage of mental illness bankrupts families and places a tremendous burden on taxpayers through suicide, homelessness and inappropriate "criminalization" of mental illness,
- parity is affordable for employers and

health plans – the Congressional Budget Office estimates that this legislation will result in premium increases of only .9% – costs that are far outweighed by lower absenteeism and higher productivity when mental illness is treated earlier, and 34 states have enacted parity laws similar to S 486/HR 953, but even these laws offer no protection for workers and their families that receive coverage through self-insured ERISA plans.

Smoking from page 9

The researchers observed that MAO B activity in the peripheral organs was reduced by one-third to almost one-half in smokers compared with nonsmokers.

The scientists caution that the effects of this finding remain unknown at present. "The consequences of reduced levels of this important enzyme need to be examined in greater detail," explains Dr. Fowler. "Though we do not know the

physiological effects of such a reduction in MAO B in peripheral organs, we do know we need the enzyme to break down blood pressure-elevating chemical compounds in certain foods, as well as those that are released by nicotine. Thus, it is possible that lower levels of this enzyme in peripheral organs could have medical consequences."

Previous research by these scientists has shown that the level of MAO B is lower in the brains of smokers.

Co-Occuring from page 36

difficult. Also, coordination of care with treating psychiatrists must always be at the forefront."

On the pharmacological side of the equation, research suggest that clients being treated with lithium for bipolar disorder were only about one-eighth as likely to commit suicide as those not taking the drug. However, lithium requires regular blood tests to ensure its efficacy. Similarly, a recent study of schizophrenic clients showed that Clozapine reduced the number of suicide attempts in that population as well. Consequently, the FDA has now proposed

the drug for such suicidal clients. "We at F.E.G.S, of course, are particularly concerned with the risk of suicide with our dually diagnosed clients" says Joyce Kevelson. "By working with clients on their substance abuse and mental illness issues simultaneously, we can educate consumers and reduce the risk."

The factual materials in this article have been taken from: Harvard Mental Health Letter, Vol. 19, Nos. 11 and 12, May and June, 2003 - Confronting Suicide I and II. and Integrated Treatment for Dual Disorders, A Guide to Effective Practice, K. Musser, et al, The Guilford Press, New York, 2003, p. 8-9, 117-118.

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Lessons from page 22

anything that came her way, except depression. I remember the first time she was hospitalized since I had known her. It was my first visit to an inpatient mental health unit. I was scared, they buzzed me in and I walked towards the desk as the door locked behind me, unsure of what I was supposed to do or what to expect. I stood at the nurses station unnoticed for several minutes and finally someone acknowledged my presence and said I had to sign in as they paged my friend to come to the desk. The person that emerged to greet me was not my friend but some other person that was in a seemingly drug-induced haze and could barely speak. I was horrified! What had happened to this vivacious person? After a few weeks or days she would rebound and return home and immediately back to work, a place where I believe she truly found joy. This vicious cycle of rehospitalization would occur many times over the course of the next two years and I truly got a sense of the struggle for wellness, and the energy that is required to battle your own mind.

In June of 1999 I was preparing to vacation in Florida for a few days and once again, Renee was in a deep depression, following several recent hospitalizations and the fear of another. A few days before my departure, she gave me a letter. It was a resignation letter, stating that when I returned from Florida she would no longer be working for our agency. I had suspicions about the meaning of this letter, was it a resignation letter or something more? I talked with her about it and she shared her despondency with me over being lonely. She had recently moved into her own apartment which most people would think is a good thing but in her case, I think not. She was also distraught over a love interest that was not reciprocating her affection which I tried to minimize saying there were "other fish in the sea". How stupid of me to minimize her feelings. I encouraged her to talk to her therapist and doctor to perhaps try a medication change. What I really wanted was for her to go back in the hospital where I thought she would be safe. I didn't realize at the time that there is no safe place.

She was admitted to the hospital the day before I left for Florida. I remember my sense of relief that I would not have to worry about her while I was away and that whatever was wrong would be resolved when I got back and we could talk about her coming back to work. I left for Florida, had a wonderful few days away and when I got home I received a message from a professional colleague asking me to call as soon as I got home. The message seemed a little strange, but I run a mental health agency. Perhaps something had occurred while I was away that I needed to know before returning to work. What an understatement. That was the call.

Renee had committed suicide while in the hospital and on a five minute watch. How could this have happened?!! What do you mean she's dead?! I can't believe this is happening!! Of all the times she's cut herself in the past, she's always survived, how could this have happened? Well, she tried something new and it worked, she hung herself with her shoelaces. Again I think to myself, what is your life like that you would even think to do such a thing? So much pain.

My first thought was, how could she have done this over a guy? Again, stupidity on my part. This had nothing to do with him, it was about so much more. I then came to learn that she left letters in her apartment before going into the hospital for important people in her life, indicating to me that this had all been carefully planned on her part. She was so smart. She knew that if she was hospitalized again, she would end up back at the state hospital, a place she never wanted to return to. People there told her that all she would ever amount to would be "a mental patient on the back ward of some state hospital". They couldn't have been more wrong. Renee was so much more than that, she was a peer specialist, aiding other consumers in locating services and support. She was the first peer to staff our peer bridging program at our local hospital, aimed at reducing rehospitalizations through community support. She was a mother to a son she loved more than anyone on the face of this beautiful earth. She was a daughter and a sister, and to me and many others, she was a friend, someone who touched our lives in a very special way with her smile, a hug, her delicious cookies (we shared a love of baking) and unconditional love and friendship.

It took a long time for me to really understand what her death meant. It meant peace. Peace from an illness that robbed her of opportunity, peace from memories of the past that haunted her waking and sleeping hours, peace from the exhausting effort it took for her to put a smile on her face and greet the cold cruel world every day. Peace from trying to be what everyone thought she should be instead of just being herself.

I learned a lot of hard lessons from my short friendship with Renee. First, you cannot save people, they have to want to be saved. Second, what I want for others is not necessarily what is best for them, they need to make their own choices and live with the consequences. Finally and most importantly, live every day as if it is your last, tell everyone you care about how you feel about them. Let them know how much they matter to you and what they give to the world, each of us has something unique to offer. I remember every time Renee would end a conversation with me, she would always say, "love ya". I know that she did and that was a comfort to me after she died, and even still today.

I am reminded every day through my work that many others are here struggling with depression, addiction, anxiety, bereavement and doing what they can to recover. They are an inspiration to me and remind me every day what is really important. Renee's picture is on my desk along with an angel. I consider her my guardian angel, reminding me that with hope all things are possible and that a friendship doesn't have to be long to be deep. Of course I wish she were still here but she's where she wanted to be, at peace finally and I am still here, with her in my heart, sharing the gift of hope so that others might find peace and purpose here in this world.

Mind Thing from page 52

Be sure to ask yourself if you are consuming a variety of foods. Do you have at least two servings of lean meat, fish, poultry daily? Are you consuming the minimum of five fruits and vegetables a day? Do you have at least two servings of dairy daily? Are you including whole grain breads and cereals? Choosing whole wheat and whole grain versions of breads and starches will help you meet daily dietary fiber requirements. Most fruits and vegetables and beans are good sources of dietary fiber. Soluble fiber binds bile acids and cholesterol in the intestinal tract, preventing their reabsorption. Increasing soluble fiber in the diet can help to reduce serum cholesterol. The easiest way to do this is simply to eat more fruits and veggies. Raspberries are one of the richest source of fiber (one cup contains 40 grams) their fiber is in the tiny seeds. To be worthwhile as a fiber source, a cereal should be at least 4 and preferably 5 grams of bran per one ounce serving.

As a registered dietitian, my experience has taught me that many people gain weight not because they eat the wrong foods but because they tend to be clueless about portion sizes. In sessions with clients, I will use a can of Crisco and bags of potato chips, cheese doodles, nachos etc. to instruct on the fat and salt content of their favorite foods. I will allow the client to try and give the amount of fat by using the Crisco for each of the food items. Most clients are amazed to find out how much fat, salt and sugar are in their snack foods. Most

do not forget this picture so fast.

Not only did they see the amounts of salt, fat and sugar they are consuming but, the hands on activity very often leaves a lasting impression. Working with clients has taught me that most of us need clear understanding of portion control and how to gauge portions when we eat out-so we do not overeat and sabotage our efforts.

The key to healthy eating is developing meal plans that help you achieve good sensible eating behavior. Meeting with a registered dietitian (known as a R.D.) to review what foods you like will ensure a skilled therapist to assist you with meal planning and your own nutrition concerns. An R.D. is an expert about portion control and can evaluate your food intake to ensure you are getting the vitamins and minerals needed.

Lastly, the more you exercise the more you will enjoy it. It is a wonderful way to unwind. Think about walking on trails or the local track while catching up with a friend or biking on a country road. When you become involved in more regular activities, you're more prone to eat when you're hungry instead of eating out of boredom or loneliness. Good food and the good feeling it engenders at the table is not only a delight but it is most necessary for our well being.

Let food be your medicine and medicine be your food (Hippocrates). Using your mind is the best way to trim your body.

For more information on registered dietitians, visit the American Dietetic Association at www.eatright.org.



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Eastern from page 27

some even say illusory. What thoughts and feelings are permanent? How often do the "I love you's" of today, become the "I don't care for you's" of tomorrow, only to become the "I like you's" of a later time? "People change" is a way of understanding that, yet we often treat our own emotions as if they are permanent and unchanging. In fact, the very nature of depression is that the oppressive thought/feeling states, which descend, appear to the person in the midst of the depression as if they are permanent: they have always been there, and will always be. This is what can lead to a sense of hopelessness, when the truth is that these moods are anything but permanent. How can one remember this in the midst of a depression? Talking to a friend or counselor can make a difference. Availing oneself of the support of help-lines, joining peer support groups, taking useful medication, and remembering the wellness supports in one's life can all lead to a better pattern of choices than those of a depressive cycle.

One way to control the downward depressive spiral is to get some distance from the emotions you are experiencing. This is expressed in the statement, "Have your feelings, don't become them." Emotions arise and subside, find some solace in the pauses between the ebb and flow. "The difference between despair and hope is often a good night's sleep." This quote adequately summarizes the nature of emotions: transitory, subject to change, yet seemingly so entrenched and real when they are being experienced, particularly when one is in the midst of any strong emotional reaction, such as a depression (or great success, or falling in love, for that matter.) Recognizing that one is depressed is the first step to unraveling the pattern. The simple statement "I am depressed" reflects the emotional distance that allows one to understand the temporary nature of the depressing thoughts and feelings. It implies a future when one may not be depressed any longer. No depression is permanent, even though it can seem that way in the midst of one. In Steel Magnolias, Shirley Maclaine says "I've just been in a bad mood.....for 39 years." Although we may sometimes feel like this is the case, in any day good moments occur. Recognize them for what they are: a smile offered or received, a kind word, a moment to pause and look at nature. Accentuating the positive, acknowledging its existence is a powerful measure to cope with negativity. Some teach that one should repeat affirmations such as "The light of love is within me" even when one feels quite the opposite. Words can be powerful in and of themselves.

The best way to deal with suicidal feelings is to cut them at the root, the root being the negative thought/feeling/action patterns which feed the depression. (Of course, if one is feeling like one is capable of hurting oneself, or another, and liable to, the best course of action is to seek professional help.) But, prior to arriving at the extreme state of contemplating, planning, and deliberately arranging things such that one could carry out an attempt on one's life, the best course of action is to establish a daily practice of wellness. "How do you get to Carnegie Hall?" "Practice, practice, practice."

"How do you get to a state of wellness?"
"Practice, practice, practice." Remembering that high and low feelings, euphoria and depression are transitory, one can practice activities that support wellness and a reduction of symptoms. Mary Ellen Copeland's Wellness Recovery Action Plan is an extremely effective tool. The WRAP plan is particularly effective in enhancing one's wellness (www.mentalhealthrecovery.com). The essence of this plan is to spend some time identifying and listing activities which support wellness, (e.g., talking to a friend, connecting

with a life partner for ten minutes, taking a hike, meditating, taking a hot bath, talking to a professional counselor, taking proper medications, repeating affirmations, making or listening to music, etc.) and choosing to practice them daily.

When severe depression arises, with the sometimes accompanying impulses to destroy oneself, it is best to rely on the wellness activities, which one has developed in the past. One does not knit a parachute as the plane is falling to the ground; the parachute is better prepared over the course of time, so it is available when needed. In a similar way, the connections to others, nature, and one's own self which one can develop can serve well in times of crisis. Nurture and acknowledge the goodness within yourself, and you can limit the pattern of suicidal thoughts which may arise. The thoughts may still arise, but you may find you are able to limit their disruptive influence on your day. Like in a meditation, you can acknowledge the presence of the thought, assess that you are not bound to act upon it, and then move on. A depression that does not lead to suicide can often be a spur to one's growth, and a blessing in disguise. Just as there are knee-jerk reactions, there can be "psyche-jerk reactions"; we may find ourselves reacting in habitual ways to stressors. These can include thoughts of worthlessness, hopelessness, despair, embarrassment; many things can be triggers. When we notice we are in the midst of a psyche jerk reaction, we can simply choose from a previously developed list of wellness tools such as following the breath, talking to a friend, journaling, taking a walk.

The wisdom of the East has been helpful to many in learning to cope with life's most difficult moment. To be able to stay in the moment is a great gift, in that it allows the hope for one to relax and accept what comes one's way with an easy heart. Some yogis describe an attainable state in which honor and shame, joy or sadness, fortune or poverty can all be accepted from a state of grace. For most of us, this seems like an unattainable ideal, sometimes we just want to get through the day. We can always take some refuge in relaxing into the present moment no matter what the occurrence. Think you're doing well? Relax while following your breath. Think you're doing terribly? Relax by following your breath. In this way, we can prepare for all the moments of life, and prevent the winds of life from blowing us over.

We are all going to die one day, and this nature of preparation (remaining in the moment, relaxed in one's breath) can be very useful at moments of extreme transition, of which death is the ultimate. Many of the earth's people believe in reincarnation. In the face of that belief, suicide makes no sense whatsoever: one will simply have to return, again and again, to deal with the feelings and issues which one was trying to escape from. Even if one does not believe in a life after this one, suicide makes no sense whatsoever. A Creator put us here certainly for a different purpose than to put an end to pain. The nature of pain can be such that it leads to a feeling that it will be endless; the yogic practice of being in the moment frees one up from too much attachment to any particular moment. You feel one way this moment, don't get too happy about it: it will pass. You feel another way the next moment, don't get too upset about it: this will pass, too. Pay attention to the breath, let that attention be a vehicle to carry you across the waves of samsara. Develop your wellness recovery plan, practice wellness, and see the best in yourself and others. Remember that every moment has its successor, that all things must pass. In this way, one can move towards living a more positive life.

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Read This from page 15

greatly in their capacity to withstand pain. When pain exceeds pain-coping resources, suicidal feelings are the result. Suicide is neither wrong nor right; it is not a defect of character; it is morally neutral. It is simply an imbalance of pain versus coping resources.



You can survive suicidal feelings if you do either of two things: (1) find a way to reduce your pain, or (2) find a way to increase your coping resources. Both are possible.

Now I want to tell you Five things to think about.

1) You need to hear that people do get through this -- even people who feel as badly as you are feeling now. Statistically, there is a very good chance that you are going to live. I hope that this information gives you some sense of hope.

- 2) Give yourself some distance. Say to yourself, "I will wait 24 hours before I do anything." Or a week. Remember that feelings and actions are two different things - just because you feel like killing yourself, doesn't mean that you have to actually do it right this minute. Put some distance between your suicidal feelings and suicidal action. Even if it's just 24 hours. You have already done it for 5 minutes, just by reading this page. You can do it for another 5 minutes by continuing to read this page. Keep going, and realize that while you still feel suicidal, you are not, at this moment, acting on it. That is very encouraging to me, and I hope it is to you.
- 3) People often turn to suicide because they are seeking relief from pain. Remember that relief is a feeling. And you have to be alive to feel it. You will not feel the relief you so desperately seek, if you are dead.
- 4) Some people will react badly to your suicidal feelings, either because they are frightened, or angry; they may actually increase your pain instead of helping you, despite their intentions, by saying or doing thoughtless things. You have to understand that their bad reactions are about their fears, not about you.
- 5) But there are people out there who can be with you in this horrible time, and will not judge you, or argue with you, or send you to a hospital, or try to talk you out of how badly you feel. They will simply care for you. Find one of them. Now. Use your 24 hours, or your week, and tell someone what's going on with you. It is okay to ask for help. Try:

- Send an anonymous e-mail to The S a m a r i t a n s (h t t p : // www.befrienders.org/talk.htm)
- Call 1-800-SUICIDE in the U.S.
- Teenagers, call Covenant House NineLine, 1-800-999-9999
- Look in the front of your phone book for a crisis line
- Call a psychotherapist
- Carefully choose a friend or a minister or rabbi, someone who is likely to listen

But don't give yourself the additional burden of trying to deal with this alone. Just talking about how you got to where you are, releases an awful lot of the pressure, and it might be just the additional coping resource you need to regain your balance.

Suicidal feelings are, in and of themselves, traumatic. After they subside, you need to continue caring for yourself. Therapy is a really good idea. So are the various self-help groups available both in your community and on the Internet. Well, it's been a few minutes and you're still with me. I'm really glad.

Since you have made it this far, you deserve a reward. I think you should reward yourself by giving yourself a gift. The gift you will give yourself is a coping resource. Remember, back up near the top of the page, I said that the idea is to make sure you have more coping resources than you have pain. So let's give you another coping resource, or two, or ten...! until they outnumber your sources of pain.



Now, while this page may have given you some small relief, the best coping resource we can give you is another human being to talk with. If you find someone who wants to listen, and tell them how you are feeling and how you got to this point, you will have increased your coping resources by one. Hopefully the first person you choose won't be the last. There are a lot of people out there who really want to hear from you. It's time to start looking around for one of them.

Now: I'd like you to call someone.

"Reprinted with permission. From the website, Suicide: Read This First (http://www.metanoia.org/suicide) was written by Martha Ainsworth based on work by David Conroy, Ph.D. To talk with a caring listener about your suicidal feelings, in the U.S. call 1-800-SUICIDE any time, day or night. Online, send an anonymous e-mail to jo@samaritans.org for confidential and non-judgmental help, or visit www.befrienders.org."

NARSAD from page 20

men attempt suicide, men are more than four times more likely than women to actually kill themselves. There is some evidence that this difference stems from the methods men and women use. Women are more likely to take pills and to slit their wrists, actions that are not immediately fatal and can be thwarted if medical help is received in time. Men, on the other hand, are more likely to shoot themselves or jump from a high building.

How to Help a Suicidal Loved One

Know the warning signs!

Most suicidal people give clues about their feelings. Don't be afraid to ask someone you are worried about if he or she is thinking of taking his or her own life. You cannot make someone suicidal by asking a direct, caring question. Tell your loved one that you are worried and give specific reasons why. Stress that he or she is very important to you and to other people. Encourage that person to get help through a psychiatrist, social worker, clergy member, or other mental health professionals.

How NARSAD is Helping

Since 1990, the National Alliance for Research on Schizophrenia and Depression (NARSAD) has awarded 38 separate grants to medical researchers who are investigating the causes of suicide. NARSAD has funded nearly \$3 million in research to help find the causes and cures for the severe mental illnesses which lead people to feel that suicide is their only option.

NARSAD-funded researchers have investigated many different aspects of suicide including: the chemical/biological causes of suicide; the effect of hormones in suicidality; how early detection and intervention (with medication and talk therapy) in patients with severe mental illness may prevent suicide; identifying behaviors that may indicate suicidality; the biological differences between adults and adolescents who exhibit suicidal behaviors; psychosocial risk factors for teenage suicide; the relationship between poor sleep quality and suicidal ideation; the effect of medications prescribed to treat mental illness on suicidality; why some people with major depression commit suicide and others do not; and the effect of substance abuse on suicide rates.

NARSAD is committed to funding these and future studies to provide hope for those suffering from severe mental illnesses. To learn more about NAR-SAD, please visit us at www.narsad.org.

Constance E. Lieber is the President of NARSAD (the National Alliance for Research on Schizophrenia and Depression). She is a frequent contributor to Mental Health News, and serves on its Advisory Council.

Helping Families from page 54

well again, often it is because they become in touch with their natural desire to live and thrive. Just like sap in the trees, this healing force can rise in everyone.

By relating to that which is lifegiving, you encourage the healing force to grow.

We must always be conscious of the kind of image we are projecting onto a given person, particularly someone who is grieving. Your view of the other is always being communicated whether you want it to be or not. Can you look through the eyes of strength and love? How you choose to perceive him is up to you. You can choose to see his courage, aliveness and ability to love rather than his weak spots.

The way in which you persistently choose to see another person will also inevitably effect how you see yourself.

Process

- Write down your description of the family members.
- List whatever adjectives come to your mind. Are you focusing on their weaknesses or their strengths?
- Find five beautiful things about each person exactly as they are now. Write them down. Share them with him
- Find five beautiful things about yourself, just exactly as you are

- now. Write them down. Share them with your friend.
- Find five positive things about the situation you both are presently in.
 Write them down. Share these, too.

Seeing With Love

Seeing with love means relating to another person's strong points. This strengthens, enables and sets them free. Seeing with love respects another's choices. Dependency holds a person too closely and causes weakness in many ways.

A good way to know if we are seeing with love and encouraging another is to look at the effects our behavior is having upon the individual. Do they bloom a little around us?

It is also important to always ask ourselves if we are giving to another in order to hold them or to help them grow. When we truly love another, we also feel loved and complete. There is nothing the person has to do to earn or deserve our love. We love and respect the person just because they exist. This is the very best healing and cure for grief, loss and anguish of all kinds.

Dr. Brenda Shoshanna is an author and psychologist in practice in Manhattan. You can visit her website at www.brendashoshanna.com, e-mail at Topspeaker@Yahoo.com, or by phone at 1-866-656-8337.

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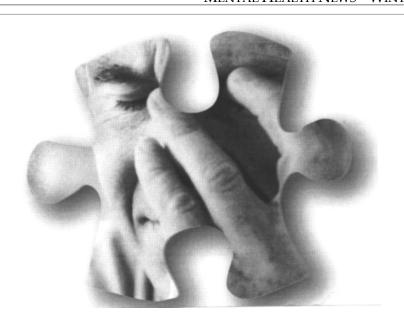
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